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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 12/10/24-12/13/24 and 12/16/24-12/17/24 with a telephone exit on 12/17/24.	{D 000}		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure three exit doors had a sounding device that was audible throughout the facility when the doors were opened which was accessible to five residents (#3, #7, #8, #10, #12) who were identified as disoriented. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 34	D 067		

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D 067	Continued From page 1 beds. Review of the facility's census on 12/10/24 revealed there were 22 residents residing in the assisted living facility. Review of the facility's wandering resident's agreement (undated) revealed: -The facility was not a locked-door facility. -Although precautions had been taken to help ensure the residents did not wander from the facility, the possibility remained that someone could wander without notice. Observation on 12/10/24 at 8:00am revealed no alarm sounded when the survey team entered the facility through the front entrance. Observation of the exit door on the south hallway on 12/11/24 at 3:44pm revealed: -The exit door on the south hallway was opened and no alarm sounded. -No staff were in the hallway. -At 3:46pm, a resident walked down the hallway and out the south hallway exit door, and no alarm sounded. Observation on 12/11/24 at 4:27pm revealed: -The exit door on the north hallway was opened and no alarm sounded. -No staff were in the hallway. Observation of the facility on 12/12/24 at 8:00am revealed the front entrance door was alarming and a personal care aide (PCA) was observed using a key to turn the alarm off at the panel in the hallway. Interview on 12/16/24 at 1:12pm with the PCA revealed:	D 067		

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-She had never cut the alarm off at the panel box.
-She was "just wiping off" the alarm box, she was not cutting the alarm off.

Observation of the facility's front entrance door on 12/12/24 at 8:16am revealed the Administrator entered the facility and the door did not alarm.

Observation of the facility's front entrance door on 12/12/24 at 9:24am revealed when the surveyor was exiting the facility, the door did not alarm.

Observation of the facility's front entrance door on 12/12/24 at 10:00am revealed that when the surveyor reentered, the door did not alarm.

Observations of the north and south hallways on 12/12/24 at 2:08pm and 2:10pm revealed:
-At 2:08pm, a resident entered the north hallway door and a second resident exited the same door.
-The alarm at the control panel located between the north and south hallways sounded for 50 seconds when the north hall door was opened; staff did not respond to the control panel and did not check any of the three visible doors.
-At 2:10pm, a resident exited the facility to go to the smoking area on the south hallway; the door alarm did not sound.
-The door alarm on the south hallway did not sound when a second resident opened the door and entered the facility from the smoking area.

Observations of the north hallway on 12/12/24 at 4:25pm and 4:30pm revealed:
-At 4:25pm, a resident entered the facility from the outside porch; the door alarmed for 15 seconds, and staff did not check to see who exited or came in.
-The door had a self-closing hinge, but it did not pull the door closed and it did not latch; the door

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stayed ajar.
-At 4:30pm, a resident opened the door to go outside and staff did not come to the door; the alarm went off for 10 seconds and then stopped.

Observations of the door on the north hallway on 12/13/24 at 8:20am and 10:40am revealed:
-At 8:20am a resident exited the building through the door on the north hallway.
-The door alarm sounded.
-Staff did not come to the door to check on the resident.
-The alarm stopped.

Observation of the Supervisor on 12/13/24 at 9:05am revealed:
-The Supervisor was standing near the door alarm panel in the hallway half-way between the north and south hallway exit doors.
-She was talking with someone, and she had her back to the north hallway door.
-The door alarm sounded, and she stepped over to the panel while still talking and pushed a red button.
-The door alarm stopped sounding.
-The Supervisor remained in the hallway and did not look up at the doors to see if a resident had exited.

Observation of the Director on 12/13/24 at 9:40am revealed:
-She was in the office and the door alarm could be heard alarming.
-She used a handheld electronic device to cut the alarm off.
-She did not leave the office to determine why the door alarm was alarming.

Observation of the exit door on the south hallway on 12/14/24 at 11:01am revealed:

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-The exit door on the south hallway was opened by a resident and no alarm sounded.
-No staff were in the hallway.

Observation of the exit door on the north hallway on 12/14/24 at 11:14am revealed:
-The exit door on the north hallway was opened by the surveyor and no alarm sounded.
-No staff were in the hallway.
-No staff opened the exit door to see who exited the door.
-At 11:16am, the surveyor reentered the facility, no alarm sounded, and no staff were in the hallway.

Interview with a PCA on 12/11/24 at 6:59pm revealed:
-The exit doors were locked at 9:00pm.
-The alarm on the exit door in the south hall was not working.
-When she heard a door alarm go off, she always checked to make sure no one had gone outside.
-When the front door was closed, the door alarm went off every few seconds.
-If the front door was propped open so it did not close, it would prevent the door alarm from buzzing every few seconds.
-She was not aware of any residents who needed to be monitored when they went outside.
-There was a resident who would sneak out the door on the south hall at night to smoke after smoking hours and after the doors were locked.
-The resident would leave the door cracked just enough that it did not close.

Interview with a resident who resided on the north hall on 12/12/24 at 4:30pm revealed:
-The door on the north hallway usually made a noise when he went out of it.
-The door did not "click" all the time and the alarm

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on the door would not sound because it was already open.
-Anyone could go outside alone during the day; there were no restrictions.
-At night the alarm would go off every 15 minutes.
-Sometimes the door alarm went off all night.
-There was a red light on the control panel; the residents could push a red button and turn off the alarm so they could get some sleep.

Interview with a medication aide (MA) on 12/13/24 at 9:04am revealed:
-The door alarms were never cut off.
-The alarm on the south hallway exit door was broken.
-She was not sure how long the door alarm had been broken, maybe "a couple of weeks."
-If the exit door on the north hallway was not shut all the way, the alarm would not sound when the door was opened.
-If the front door was not shut all the way, the alarm would not sound when the door was opened.
-The front door was cracked at times to keep the alarm from going off.
-None of the residents needed supervision to go outside.
-The purpose of the door alarms was so the staff knew when residents went outside.
-She tried to look to see who went outside but she did not look every time.

Interview with a second MA on 12/16/24 at 11:00am revealed:
-Door alarms were supposed to be on 24/7.
-She did not know why the doors did not alarm at times.
-The door alarms always went off when someone opened the door.

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D 067	Continued From page 6 Interview with the Supervisor on 12/16/24 at 11:42am revealed: -Staff were always in the hallway. -When staff heard the door alarms, they looked at the alarming door. -She knew there were times the south hall exit door did not alarm. -She was not aware there were times the north hallway exit door did not alarm. -She was aware there were times the front entrance door did not alarm. Interview with the Director on 12/16/24 at 3:11pm revealed: -All the doors had alarms, and all the alarms were working. -She did not know the south hallway exit door was not working. -The front door alarm worked if the door was fully closed. -If the door was not completely closed, an alarm would continue to go off. -Sometimes if the front door was not closed, it affected other doors as well. -She made the assumption staff had checked the door and she used the remote to cut the alarm off. -When a door alarmed, she expected staff to check the exit doors to see who went out and if they did not see a resident, they were to do a headcount. -Nine times out of ten when a door alarmed it was going to be a hallway exit door. Interview with the Administrator on 12/16/24 at 5:49pm revealed: -He was not aware of any door alarms not working. -Alarms were activated on all exit doors 24/7. -If an alarm sounded, he expected staff to check	D 067		

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to see why the alarm was sounding.
-Staff had reported sometimes if the front door was not closed, the alarm would continuously sound.
-He was not aware the alarm on the south hallway exit door was not working.
-He was not aware the alarm on the north hallway exit door would not sound at times when the door was opened.

Telephone interview with the facility's contracted mental health provider (MHP) on 12/12/24 at 11:59am revealed the front door of the facility had never alarmed when she entered the facility, but she had heard door alarms on the exit doors on the hallways when opened.

Telephone interview with the facility's former contracted primary care provider (PCP) on 12/11/24 at 4:31pm revealed:
-Any resident with dementia needed to be monitored.
-It would be ideal to have chimes on the exit doors or a receptionist to monitor the doors.
-The exit doors should be locked at night.

1. Review of Resident #8's most recent FL-2 dated 11/08/23 revealed:
-Diagnoses included dementia, metabolic encephalopathy, and asthma.
-Resident #8 was constantly disoriented.

Observations of the north hallway on 12/12/24 at 4:25pm and 4:30pm revealed Resident #8 exited the door and the door alarm did not sound.

Observations of the door on the north hallway on 12/13/24 at 8:20am and 10:40am revealed:
-At 10:41am Resident #8 exited the building alone through the door on the north hallway.

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D 067	Continued From page 8 -The door alarm did not sound. Interview with Resident #8 on 12/12/24 at 11:17am revealed: -She went outside to smoke. -She went outside to smoke today, 12/12/24. -There were no staff on the porch, but other residents were around. -She did not leave the porch. Telephone interview with Resident #8's family member on 12/16/24 at 10:35am revealed: -Resident #8 went outside on the porch to smoke. -She did not think Resident #8 would leave the porch. Interview with a MA on 12/13/24 at 9:04am revealed Resident #8 forgot a lot, like she would eat and then an hour later the resident forgot she had eaten. Interview with another MA on 12/16/24 at 11:00am revealed: -Resident #8 would ask for a cigarette even though she had just smoked. -Resident #8 went outside and smoked and came back inside the facility. -Sometimes staff would be with Resident #8 because another resident would snatch Resident #8's cigarettes. Interview with the Supervisor on 12/16/24 at 11:42am revealed: -Resident #8 went out on the porch to smoke. -Resident #8 did not need to be supervised. -Resident #8 would not leave the porch because the resident was afraid that she would fall. -Resident #8 was forgetful. Interview with the Director on 12/16/24 at 3:11pm	D 067		

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revealed Resident #8 would not leave the porch because she was scared of falling.

Interview with the Administrator on 12/16/24 at 5:49pm revealed:
-He had never thought about how Resident #8's memory was.
-Resident #8 went outside to smoke on the porch.
-Resident #8 would not leave the porch unless someone was with her.

Telephone interview with Resident #8's PCP on 12/17/24 at 12:08pm revealed:
-She saw Resident #8 on 09/03/24.
-Resident #8 was forgetful.
-She thought Resident #8 should be supervised when she went outside of the facility.

2. Review of Resident #3's most recent FL-2 dated 11/06/23 revealed:
-Diagnoses included schizophrenia, mild retardation, diabetes mellitus type 2, and hypertension.
-Resident #3 was intermittently disoriented.

Review of Resident #3's mental health provider (MHP) after-visit summary dated 12/02/24 revealed:
-Resident #3 was an unreliable historian due to intellectual disability.
-Resident #3's thought process was disorganized and illogical.
-Resident #3's judgment and insight were impaired.
-Resident #3 had a moderate memory impairment.

Observation of the north hallway exit door on 12/13/24 at 2:39pm revealed:
-Resident #3 walked out of the exit door, onto the

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porch, down the steps, and across the parking lot of the adjoining business.
-Resident #3 went out the end of the parking lot and started walking up the side of the road approximately 100 feet.
-He stopped and stood in place on the side of the road for 2 minutes, and then turned around and returned to the facility.

Interview with Resident #3 on 12/13/24 at 2:56pm revealed:
-He liked to go outside.
-He had never walked away from the facility.
-He could go outside anytime he wanted to.

Interview with a medication aide (MA) on 12/16/24 at 11:00am revealed:
-Resident #3 had never shown any confusion.
-Resident #3 liked to sit outside in the rocking chairs on the porch.
-She did not know Resident #3 had walked across the parking lot toward the road on 12/13/24.
-Her concern was why Resident #3 walked off "like that" as his safety was important.

Interview with the Supervisor on 12/16/24 at 11:42am revealed:
-She had never seen Resident #3 walk off the porch unless someone was walking with him.
-If he did walk off the porch and go to the road, staff would need to keep an eye on him.
-She would like to know what triggered Resident #3 to walk up the road.
-Resident #3 would need to be watched so he did not go to the road again.

Interview with the Director on 12/16/24 at 3:11pm revealed:
-Resident #3 went outside.

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-Resident #3 did not need to be supervised.
-Resident #3 was usually in his room or the living room.
-If Resident #3 went outside he let a staff member know where he was.
-On Friday, 12/13/24, she knew Resident #3 was mad because he wanted a drink and maybe that was why he left the facility.
-She was concerned Resident #3 went out the north hall exit door as he usually did not go out that end of the facility.
-If she went and talked to Resident #3 about walking to the road, he would tell her he would not do it again.

Telephone interview with Resident #3's mental health provider (MHP) on 12/12/24 at 11:59am revealed:
-Resident #3 had schizophrenia and a developmental disability and she was not comfortable with him going outside without staff knowing the resident's whereabouts.
-She would worry about Resident #3 not being supervised outside the facility because he might hear or see things that were not there.

Interview with the Administrator on 12/16/24 at 5:49pm revealed:
-He did not think Resident #3 needed supervision.
-Resident #3 was not going to leave the property.
-If Resident #3 left the property on 12/13/24, it was out of the ordinary, and the resident would need to be watched.

Telephone interview with Resident #3's primary care provider (PCP) on 12/17/24 at 12:08pm revealed:
-She saw Resident #3 on 09/03/24.
-Resident #3 had schizophrenia, was confused,

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and only oriented to person.
-She thought Resident #3 should be supervised when he went outside of the facility.

3. Review of Resident #7's current FL-2 dated 07/07/24 revealed:
-Diagnoses included schizoaffective disorder, diabetes, chronic pain, and migraines.
-She was intermittently disoriented.
-She was admitted 04/01/19.

Review of Resident #7's care plan dated 02/21/24 revealed:
-Resident #7 was sometimes disoriented.
-Resident #7 was forgetful and needed reminders.

Interview with a medication aide (MA) on 12/13/24 at 9:04am revealed Resident #7 forgot stuff and was "out of it sometimes."

Interview with another MA on 12/16/24 at 11:00am revealed:
-Some days Resident #7, "may seem off and some days she was okay."
-Resident #7 had never walked off.
-Resident #7 knew when to come back.

Interview with the Supervisor on 12/16/24 at 11:42am revealed Resident #7 needed to be supervised when she went outside because the resident was prone to fall.

Review of Resident #7's mental health provider (MHP) after-visit summary dated 12/02/24 revealed:
-Resident #7 was an unreliable historian due to chronic psychotic disorder.
-Resident #7's thought process was illogical.
-Resident #7's judgment and insight were

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 13 impaired. -Resident #7 had a moderate cognitive decline. Telephone interview with Resident #7's former primary care provider (PCP) on 12/11/24 at 4:31pm revealed: -She last saw Resident #7 on 09/03/24. -Resident #7 was oriented to person only, was forgetful, and lacked insight. Interview with the Director on 12/16/24 at 3:11pm revealed: -Resident #7's memory was not reliable. -When Resident #7 was not oriented she was not safe and needed to be supervised. -An example would be when the resident had a urinary tract infection (UTI), the resident was disoriented. -Resident #7 usually only went outside if other residents were going outside to smoke. -Staff would know when Resident #7 went outside because when the door was opened the alarm went off. -Sometimes other residents would holler out, "Resident #7 was going outside." Interview with the Administrator on 12/16/24 at 5:49pm revealed: -Resident #7's memory depended on the day. -Some days Resident #7 seemed better than other days, and sometimes within the same day, the resident changed. -Resident #7 would follow other residents out the door to ask for a cigarette or a drink. -Resident #7 would need supervision depending on what day it was. Based on observations, record reviews, and interviews it was determined Resident #7 was not interviewable.	D 067		

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D 067	Continued From page 14	D 067		

4. Review of Resident #10's current FL-2 dated 07/27/24 revealed:
-Diagnosis included dementia.
-He was intermittently disoriented.
-He was admitted 02/21/22.

Review of Resident #10's care plan dated 06/28/24 revealed Resident #10 was forgetful and needed reminders.

Review of Resident #10's mental health provider (MHP) after-visit summary dated 12/02/24 revealed:
-Resident #10 was a poor historian due to cognitive impairment.
-Resident #10's insight and judgement were impaired.
-Resident #10's memory had moderate impairment.

Interview with Resident #10 on 12/12/24 at 11:12am revealed:
-When the weather was nice, he liked to go outside on the porch.
-He usually stayed on the porch.
-He seldom went walking.

Interview with a medication aide (MA) on 12/13/24 at 9:04am revealed Resident #10 had dementia and did not remember anything.

Interview with another MA on 12/16/24 at 11:00am revealed:
-She did not know anything about what was marked on Resident #10's FL-2.
-He was confused when his room was changed but he was fine now.
-He went outside and talked to other residents.
-He did not need to be supervised.

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D 067	Continued From page 15 -He knew to come back inside the facility. Interview with the Supervisor on 12/16/24 at 11:42am revealed: -Resident #10 knew where his room was. -Resident #10 went outside. -Resident #10 did not need to be supervised. -The Director saw Resident #10 outside the front of the facility on 12/13/24 and told staff to go and get him. Telephone interview with Resident #10's former primary care provider (PCP) on 12/11/24 at 4:31pm revealed: -She last saw Resident #10 on 09/03/24. -Resident #10 had dementia and anxiety. -When she saw Resident #10, he was alert and oriented x 2. -Resident #10 would need to be monitored for exiting the facility. Telephone interview with Resident #10's mental health provider (MHP) on 12/12/24 at 11:59am revealed Resident #10 needed to be supervised if he went outside the facility, because he might get confused and not find his way back. Interview with the Director on 12/16/24 at 3:11pm revealed: -Resident #10 remembered "way back" like he thought his family member was four and he was actually 30. -When Resident #10's room was changed the staff put orange paper on the door so the resident would know which room was his. -She had received reports that Resident #10 had instances where he went to his old room at night. -She was in the office on 12/13/24, and looked out the window and saw Resident #10 at the end of the facility's driveway.	D 067		

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D 067	Continued From page 16	D 067		

-She turned her head for a second and when she looked back, she did not see the resident, but the staff saw him coming back up by the facility.
-He told her he was not going to the road; he was just going for a walk.

Interview with the Administrator on 12/16/24 at 5:49pm revealed:
-Resident #10 "kind of" knew what was going on.
-Resident #10's memory was not "too good."
-He did not know anything about Resident #10's retention, what the resident recalled, or for how long.
-He did not think Resident #10 needed supervision to go outside.

5. Review of Resident #12's most recent FL-2 dated 11/10/23 revealed:
-Diagnosis included dementia, cerebrovascular disease, and hypertension.
-He was intermittently disoriented.

Interview with a medication aide (MA) on 12/13/24 at 9:04am revealed:
-Resident #12 was very quiet and did not talk much.
-She thought he was alert and oriented and did not seem to be confused.

Interview with another MA on 12/16/24 at 11:00am revealed:
-Resident #12's memory was really good.
-He did not wander.
-He went outside to sit in the sun.
-He knew to come back to the facility.

Interview with the Supervisor on 12/16/24 at 11:42am revealed:
-Staff watched Resident #12 when he went outside, but the resident only went to the porch.

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D 067	Continued From page 17 -Staff watched Resident #12 because he looked like he might fall. -She would be concerned if Resident #12 went out into the yard because he could fall. Review of Resident #12's mental health provider (MHP) after-visit summary dated 12/02/24 revealed: -Resident #12 was an unreliable historian due to cognitive impairment. -Resident #12's judgment and insight were impaired. -Resident #12 had a moderate memory impairment. Telephone interview with Resident #12's MHP on 12/12/24 at 11:59am revealed: -Resident #12 had moderate dementia. -She would not feel comfortable with Resident #12 going outside without supervision. Telephone interview with Resident #12's guardian on 12/16/24 at 10:22am revealed: -Resident #12 did not talk a lot. -The resident usually only answered yes/no questions and when asked how he was he would state "I am fine." -Resident #12 did not have a history of wandering. -If Resident #12 went outside, he stayed on the grounds of the facility. -It would be ideal if staff knew when Resident #12 went outside so he could be supervised. Interview with the Director on 12/16/24 at 3:11pm revealed: -Resident #12 did not do much talking. -If Resident #12 went outside staff went with the resident because he was at risk of falling.	D 067		

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D 067	Continued From page 18 Telephone interview with Resident #12's primary care provider (PCP) on 12/17/24 at 12:08pm revealed: -She saw Resident #12 on 09/03/24. -She was not able to assess the resident's cognitive status due to his speech. -The resident took medication used to treat dementia. -She thought Resident #12 should be supervised when he went outside of the facility. Interview with the Administrator on 12/16/24 at 5:49pm revealed: -Resident #12 could go outside without supervision. -Resident #12 was not going to go far from the facility. -He did not know anything about Resident #12's orientation or memory. Based on observations, record reviews, and interviews it was determined Resident #12 was not interviewable. _____ The facility failed to ensure three exit doors were equipped with sounding devices that were activated and enabled when the doors were opened resulting in 5 residents who were documented as being disoriented, having access to the exit doors and possibly eloping, including Resident #3 who was observed exiting the facility and walking away from the facility's grounds without the staff's knowledge. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/17/24.	D 067		

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D 067	Continued From page 19 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2025.	D 067		
{D 074}	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the floors, doors, baseboards, window blinds and window sills were kept clean and in good repair in the hallway and in resident rooms S2, S3, S4, S5, S7, NC and NE. The findings are: Review of the facility's housekeeping staff duties revealed: -The list was not dated. -There was a list of monthly housekeeping staff duties that included, wiping clean baseboards and handrails in the halls, moving beds, dressers and night stands and cleaning behind, and wiping out windowsills. -Housekeeping duties done on a daily basis included, floors dust mopped, floors mopped,	{D 074}		

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{D 074}	Continued From page 20 furniture in room to be dusted, and all furniture in the resident's rooms were to be cleaned under. Review of the housekeeping checklist/log revealed: -There was no date and it was blank; nothing had been signed off as completed. -Windowsills were to be wiped off weekly and monthly. -Baseboards were to be wiped down, all furniture was to be moved and cleaned under in each residents' room, and all furniture in the [resident] rooms were to be dusted; there was no frequency listed for any of the duties. Observation of the facility's South hallway on 12/10/24 at various times between 8:10am to 4:50pm revealed: -The floor had debris and loose dirt in the corners and near doorways. -There was a blackish-brown substance on the floor outside of the common bathroom on the left side of the hallway; there were foot prints where someone had tracked the substance down the hall. -There were multiple dried spills with dust and debris stuck to them in the hallway. -There was a debris, small pieces of paper, a thick layer of dust and a cigarette butt on the floor under supply cart in the hallway. -There was a wall beside resident room S2 with a large reddish-brown smear on it. -There was a large dried splatter of brownish liquid that had dripped down the wall. -There was no staff with a cleaning cart, a mop or broom cleaning resident rooms or hallways. -There was one staff who replaced toilet paper and paper towels in the bathrooms. Observation of the facility on 12/11/24 at 8:40am	{D 074}		

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{D 074}	Continued From page 21 revealed there was a housekeeper on the North hall with a mop cart going in and out of resident rooms. Observation of the facility on 12/12/24 at 8:05am revealed the Supervisor was pushing a housekeeping cart and cleaning the bathrooms and the hallway. Observation of resident room S3 on 12/10/24 at 8:12am revealed: -There was a large area with a brownish build-up around the door knob on the outside and inside of the door; and a brown smear on the inside of the door. -There was a large brownish area on the door jamb next to the light switch and a brown build-up on the plate cover for the light switch. -There was a thick grayish black layer of dust and a large amount of black spot accumulation on the baseboards. -There was chipped paint and gouged holes in the drywall in the walls next to the bed. Interview with a resident who resided in room S3 on 12/10/24 at 8:12am revealed: -The door to his room was very dirty and need to be cleaned. -The housekeeping staff only mopped the floors and did not clean anything else. Observation of resident room S4 on 12/10/24 at 8:25am revealed: -There was flooring that had lifted and was curling up on the edges of the pieces of flooring beside one of the beds. -There were multiple chips in the corners of the individual strips of the flooring and there were several large spots of liquid that wet but had started to dry.	{D 074}		

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{D 074}	Continued From page 22 Interview with a resident who resided in room S4 on 12/10/24 at 8:25am revealed the staff cleaned his room twice a week and only swept and mopped the middle of the floor; they did not sweep under or behind anything. Interview with the second resident who resided in room S4 on 12/10/24 at 4:50pm revealed: -Staff did not regularly dust his room. -He thought his room could be cleaner. -He remembered his room was last dusted about two months ago. -His room was mopped only twice a week. -He did not think to complain about the cleanliness of his room. Observation of resident room S5 on 12/10/24 at 8:35am revealed: -There were four sets of mini blinds in the room. -There was a thick layer of dust on the blinds. -There was one set of blinds that had marks where someone had dragged their fingers down the length of the blinds and left clean tracks; there were sections where the dust had collected in clumps where dust had been moved. -There were black marks on the wall above the headboard and beside the one of the residents' bed. Interview with the two residents who resided in room S5 on 12/10/24 at 4:55pm revealed: -Staff did not clean their room. -The last housekeeper had quit about a month ago. -They noticed the dust in the room, the dirty baseboards and the dirty walls. -They did not complain to anyone because they were grateful to have a place to live.	{D 074}		

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{D 074}	Continued From page 23 Observation of resident room S7 on 12/10/24 at 8:39am revealed: -There were dried blackish-brown smears material on the floor between two beds. -There were large areas of multiple black spots on the windowsills and the baseboards in the room. Interview with the resident who resided in room S7 on 12/10/24 at 8:40am revealed: -He had diarrhea a day or so ago and he had a bowel movement on the floor. -He tried to clean it up himself with paper towels, but he could not "scrub the floor". -The staff did not clean the floor for two days after he wiped it up. -He had to complain to the staff about his dirty floor; "you could see the [expletive] on the floor". -A staff came into his room and used more paper towels on the floor; not a mop. -The floor still needed to be mopped and scrubbed today; 12/10/24. -Staff only cleaned his room twice a week and all they did was sweep and mop. -He pointed to the baseboards and said, "see how bad they are". - "I should not have to clean my own room". Observation of resident room S2 on 12/11/24 at 8:32am revealed: -There were multiple dried spots of liquid with dust stuck to them on the floor between the beds. -There was a layer of dust and debris on the windowsill. -The front and back of the door had a buildup of dirt and stains around the doorknob. Observation of resident room NC on 12/11/24 at 9:00am revealed: -There were multiple dust balls on the floor under	{D 074}		

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{D 074}	Continued From page 24	{D 074}		

the beds.
-There was a large amount of debris and dust in the corners of the room.
-There were brown smears on the door jamb on the inside of the room.

Observation of resident room NE on 12/11/24 at 9:08am revealed:
-There was a thick layer of dust on the baseboards.
-There was debris built up in the corners of the room.
-There were multiple dried liquid spills on the floor.

Interview with a resident on 12/11/24 at 9:09am revealed:
-His room was cleaned very sporadic because the facility did not have a regular housekeeper.
-He never complained about his room being dirty because they never had a regular housekeeper.
-When someone did clean his room, they only mopped.

Interview with second resident on 12/11/24 at 11:39am revealed:
-In his opinion, the facility was not a good place for anyone to have to live.
-"I mean look at the condition of this building, cracks in the ceilings and the walls, it is just not a good place."
-Someone occasionally swept and mopped the middle of the floor in his room and emptied the trash.

Interview with a third resident 12/11/24 at 8:54am revealed:
-He cleaned his own room because no one else did.
-He dusted and swept his own room.

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{D 074}	Continued From page 25 -The staff would mop his room for him about two times a week. Telephone interview with a resident's family member on 12/16/24 at 10:35am revealed: -She had noticed something on the resident's floor that needed to be cleaned. -She asked a staff member to mop the floor, and the staff member said, "that whatever it was would not come up." -She took the mop herself and cleaned the floor, and it came right up." -The staff did not mop and clean as they should. Interview with the housekeeper on 12/11/24 at 11:30am revealed: -Today, 12/11/24, was her first day. -She had cleaned at the facility when she worked as the housekeeper three years ago, so she did not require training. -She did not have a list for cleaning; she just remembered what she did before. -She was scheduled to work two days a week on Mondays and Thursdays; she was working today to help out. -She cleaned the bathrooms, toilets, tubs, sinks, and floors today, 12/11/24. -She would sweep and mop the resident rooms and empty their trash. -She would deep clean two resident rooms a day to clean baseboards. -She swept and mopped the hallways, wiped and sanitized the handrails when she worked. -There was only one housekeeper a day. -She did not know if there was a housekeeper scheduled on the days she was not there. -She had a housekeeping log she would document what she did at the end of the day. Interview with a personal care aide (PCA) on	{D 074}		

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{D 074}	Continued From page 26 12/13/24 a 9:25am revealed: -There was not a housekeeper at the facility every day. -The housekeeper was only there two to three days a week. -There was only one housekeeper since the second one quit about three weeks ago. -The housekeeping tasks were not done when there was not a housekeeper unless something needed to be done like a spill or resident accident. Interviews with the Supervisor on 12/12/24 at 8:10am and 9:35am revealed: -She was told she was the housekeeper today because the housekeeper did not show up for work that morning, 12/12/24. -They all helped when it was needed; she worked one day this week and two days last week as the housekeeper. -She would clean the bathrooms and sweep and mop resident rooms and the hallway. -She had a cleaning log she used to check off everything she did during the day. -It was located on the housekeeping cart, but she could not find it. -She thought the housekeeper who worked the day before took the log home with him or placed it somewhere else. -She looked in the medication room for the housekeeping log book but did not find the log book there either. -The other housekeeper did not have set days or a schedule he worked; she was not sure how many days a week he worked. Interview with the Director on 12/11/24 at 2:58pm revealed: -The last housekeeper quit over a month ago. -The facility had two housekeepers because one	{D 074}		

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had started to work today, 12/10/24.
-The other housekeeper worked the day before, 12/10/24 and would work on the days the new housekeeper was not working.
-There would always be at least one housekeeper a day for a full seven-day coverage.
-There was a cleaning schedule for the housekeepers to follow; it had daily, weekly, and monthly cleaning.
-The bathrooms were cleaned daily.
-The resident rooms were swept and mopped daily; including under the beds.
-The blinds and baseboards were cleaned once a month.
-The housekeeper did a certain number of rooms each day to get it all done.
-The housekeepers decided what rooms they wanted to clean weekly and monthly.
-The last time they were cleaned was the beginning of November 2024.
-The hallways and entry ways were not mopped daily.
-The hallways were spot mopped and the entire hallway was mopped every other day.
-The walls and doors were cleaned when needed; the housekeeper determined when they needed to be done or when she noticed it.
-She had tried to clean the door to resident room S3 sometime in October 2024, but she could not get it clean.
-The inside of the room doors were not on a schedule to be cleaned.
-The dusting was done weekly or as needed on the windowsills.
-She did not have a schedule, but she would randomly inspect some of the residents' rooms; when she would walk down the hall she would step inside a room.
-She did not have a list of what she was looking at; she would just look to see if anything needed

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{D 074}	Continued From page 28	{D 074}		

to be cleaned.
-She had inspected the resident rooms when they were done in November 2024 and they were fine.
-She thought the housekeeper had swept and mopped the day before, 12/10/24, because he usually did it every day.

Interview with the Director on 12/12/24 at 9:38am revealed:
-There were two housekeepers; one worked four to five days a week on Mondays, Tuesdays, Thursdays and Fridays and the other housekeeper filled in on his days off.
-The housekeeping cleaning logs were kept in a white book on the cleaning cart.
-The Supervisor was working as the housekeeper because the scheduled housekeeper did not show up for work.
-She could not find the current cleaning log or the housekeeping log book; she thought the previous housekeeper put them somewhere before she quit 3 to 4 weeks ago.

Interview with the Administrator on 12/12/24 at 8:25am revealed:
-There were two housekeepers to cover the seven-day schedule unless one called off.
-The housekeeper swept and mopped the hallways everyday and spot mopped as needed.
-The residents' rooms were swept and mopped daily including under beds and around furniture and spot mopped as needed.
-Dusting could be subjective and done as needed or at least monthly.
-Dusting included the windowsill, all surfaces including baseboards, and the window blinds.
-He did not know how often deep cleaning was done.
-Deep cleaning included pulling the beds from the wall and cleaning behind them.

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{D 074}	Continued From page 29 -Doors, door jambs, and walls were cleaned as needed. -The housekeepers had a list they followed and should be checking off as they completed task. -The housekeepers kept the list on the cleaning cart. -The Director was responsible for reviewing the housekeeping logs every day to make sure everything was done.	{D 074}		
{D 079}	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide a clean and orderly environment free from obstructions and hazards related to the presence of live mice, live bedbugs, unsecured oxygen tanks in a resident's room, and clutter in multiple residents' rooms. The findings are: 1. Observation of resident room S4 on 12/11/24 at 8:10am revealed there were rodent droppings on the window sills.	{D 079}		

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{D 079}	Continued From page 30 Observation of resident room S6 on 12/11/24 at 8:10am revealed there were rodent droppings on the floor in front of the closet. Observation of resident room NE on 12/11/24 at 9:00am revealed: -There was a pile of finely shredded tissues next to a large plastic bag in front of a closet. -There was a small pile of birdseed on the floor next to a clothes hamper. -There was a large gift bag with various items stored in it setting on the floor next to the closet; there were rodent droppings around the bag. -There was a large hole chewed in the corner of the gift bag; there were rodent droppings inside the hole. Observation of resident room ND on 12/12/24 at 2:53pm and 3:07pm revealed: -Two surveyors along with a staff member were present in the room. -A mouse entered the room from beneath the closed door, scurried across a staff member's shoe, and then ran under a bed in the room. -At 3:07 PM, the mouse emerged from under the bed, went back under the table, and exited out the door. Interview with a resident on 12/10/24 at 8:12am revealed: -He had seen rodents in the facility. -He saw a rodent in his room last night, 12/09/24. -He saw a mouse run under the dresser in his room today, 12/10/24. Interview with a second resident on 12/10/24 at 8:59am revealed: -He had seen mice in his room. -He saw a mouse last night, 12/09/24, in the corner by the wardrobe.	{D 079}		

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{D 079}	Continued From page 31 Interview with a third resident on 12/10/24 at 9:10am revealed: -He had seen a rodent in his room. -He had seen a rodent under his roommate's bed and in the trash can. -He stated, "I cannot take it" and became visibly upset when he continued to talk about the rodents. Interview with a fourth resident 12/11/24 at 8:54am revealed: -He occasionally saw mice in the hallway. -He had not seen mice in his room. Interview with a fifth resident 12/11/24 at 9:09am revealed: -He saw mice in his room and in the hallway all the time. -He had watched mice come in under his room door. -He had a mouse on his bed that morning; he woke up and "there it was in bed with me". -He swept the mouse off his bed with the back of his hand. -He told the staff about seeing mice all the time. -They always told him they were working on it. Telephone interview with the area manager from the facility's pest control company on 12/12/24 at 11:05am revealed: -They serviced the facility once a month. -The pest control technician checked in with the management at the facility when they visited. -They treated inside an the outside for rodent control. -They were especially diligent this time of year because mice came inside to escape the weather and search for food as the temperatures got colder.	{D 079}		

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-They did preventative control by placing baits far away from the facility to draw rodents away.
-The technician would make verbal recommendations when they were at the facility.

Telephone interview with the technician from the facility's contracted pest control company on 12/13/24 at 9:10am revealed:
-He serviced the facility once a month for rodents.
-If the facility called for an additional treatment he would go out.
-He used bait to lure the mice away from the facility and he changed it monthly.
-He did not spray for mice.
-He placed sticky traps in the residents' rooms where there were reported sightings.
-He had caulked holes and filled openings with steel wool to prevent entry.
-The mice situation had gotten better; because he had less reports of sightings.
-He had not put door sweeps under the exterior doors; he had advised the facility to do it themselves.
-He had spoken to the Director today, 12/13/24, and she said she was going to put them under the doors.
-The goal from the pest control company was to prevent the mice from entering the facility by exclusion.

Telephone interview with the sanitarian from the Local Department of Environmental Health on 12/12/24 at 2:00pm revealed:
-She had last inspected the facility on 09/20/24.
-She did not go into the residents' rooms as part of her inspection.
-She had not seen any evidence of rodents in the main part of the facility or the common areas.

Interview with a personal care aide (PCA) on

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{D 079}	Continued From page 33 12/13/24 a 9:25am revealed: -She had not seen mice in residents' rooms. -A resident told her he saw a mouse in his room the other night. -She told the Director and she said she would put a sticky pad in his room. -She saw mice in the common living area every night she worked. -The residents saw them when she saw them. -She had reported seeing the mice to the Director the last time she worked. -The Director said they had put bait outside the facility. Interview with a medication aide (MA) on 12/12/24 at 2:45pm revealed: -She had not seen any live mice and she had not seen rodent droppings in any residents' rooms. -No one had reported seeing live mice to her. Interview with the Director on 12/11/24 at 3:08pm revealed: -The pest control company had placed mouse traps outside, sticky traps inside, plugged outside holes and put something under the doors to keep the mice out. -It had all helped because no one had seen a mouse since they had done everything. -She had not asked the residents if they had seen any mice because if she asked someone would overhear her and they would get all worked up. -She had not seen any droppings or other evidence of mice in a while. -She would look for evidence of mice when she went into a resident's room. -Housekeeping was supposed to report to her if they saw any mice or droppings. -She asked the staff on third shift if they had seen any mice because they were seeing them on third shift.	{D 079}		

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{D 079}	Continued From page 34 -The last report of a mouse sighting was the second or third week of November 2024. Interview with the Administrator on 12/12/24 at 8:25am revealed: -The facility had a current pest control company. -He had not seen a pest control report. -There had been mice in the facility in the past. -He knew the facility might have mice because of the time of the year they came in for warmth. -There was a crawl space and a basement under the facility where the mice gained access to the inside. -He had not seen evidence of mice activity in the rooms, but he would not be surprised if there was because the residents kept snacks in their rooms. 2. Observations of resident room S8 on 12/12/24 at 8:17am and 10:10am revealed: -There were two beds in the room. -The first bed on the left had a mattress cover and two pillows on it. -The second bed on the right was made with sheets, pillows, blankets and a bedspread. -Only one resident resided in the room. -At 8:17am, there was a live bedbug crawling on the mattress cover of the unoccupied bed. -There was dust and debris on the floor around the headboard and small black spots on the posts of the headboard and the mattress cover of the unoccupied bed. -At 10:10am, there was a live bedbug crawling on the wall beside the unoccupied bed. -There was a dead bedbug on the floor near the door to the room. Interview with the resident who resided in room S8 on 12/12/24 at 10:10am revealed: -She did not have a roommate and did not use the spare bed in her room.	{D 079}		

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-She did not have bedbugs in her bed.
-She had not seen any bedbugs in the room before today, 12/12/24.
-The staff changed her bed linens once a week.
-She had bedbugs one time before and she had to move to another room while they cleaned her room and sprayed for them.
-She never saw them, but the staff had found them the last time.
-She never had itching nor had she been bitten by bedbugs.
-Nothing woke her up in the middle of the night while she slept.

Interview with a resident on 12/10/24 at 8:44am revealed:
-There was something in his bed that made him itch.
-It was some kind of black bug in his bed.
-He did not know what the bugs were, but the bugs made him itch.
-He could feel the bugs crawling on his skin.

Interview with a representative from the facility's contracted pest control company on 12/12/24 at 9:50am revealed:
-The last dates of service were 09/25/24, 10/28/24 and 11/20/24.
-They did a general spray for bugs and spiders but did not spray or treat for bedbugs unless there was a request from the facility, or the technician saw the need for treatment.
-The last time they treated the facility for bedbugs was in March 2024 and April 2024.
Telephone interview with the area manager from the facility's pest control company on 12/12/24 at 11:05am revealed:
-Bedbug treatment was a separate from the monthly pest control treatment.
-The facility would notify them of bedbugs, and

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they would schedule a treatment.
-The facility would have to remove all the residents' clothes and linen.
-The pest control company treated the mattress, box springs, dresser and closets.
-The resident would need to stay out of the room for four hours after the treatment was completed.
-If a resident had bedbugs on them and they sat in the common area, the bedbugs would crawl off the resident and into the area or onto another resident.
-Bedbugs were clear until their first feed on a blood meal and they would turn reddish-brown, their eggs were white and sticky and their fecal matter would be dark brown.
-The last time the facility was treated for bedbugs was on 04/09/24 and only room S1 was treated.
-The facility treated rooms S2 and S4 on 03/29/24.
-Five resident rooms were treated in December 2023.
-Resident room S8 had not been treated.

Telephone interview with the technician from the facility's contracted pest control company on 12/13/24 at 9:10am revealed:
-He had not treated the facility for bedbugs recently; it had been a few months.
-The facility had a bad infestation about a year ago, but they had been "knocked out".
-The Director contacted him about two to three months ago for a treatment for a few rooms.
-She had contacted him today, 12/13/24, and requested a treatment.
-The treatment had not been set up yet; he needed to contact the salesman because it was a separate cost.
-The Director had not said anything about live activity.
-They needed to treat before [the bedbugs]

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{D 079}	Continued From page 37 spread throughout the facility. Telephone interview with sanitarian from the Local Department of Environmental Health on 12/12/24 at 2:00pm revealed: -She had inspected the facility on 09/20/24. -She had not seen any bedbugs during her inspection. Interview with a personal care aide (PCA) on 12/13/24 a 9:25am revealed: -She had not seen bedbugs recently; it had been a few months. -The residents had not complained to her about bites or itching. -She did not inspect their rooms for bedbugs. -She had not seen bedbugs in room S8. Interview with a medication aide (MA) on 12/12/24 at 2:45pm revealed: -She had not seen any bedbugs in the residents' rooms. -She had not seen bedbugs in room S8. -None of the residents complained of bedbugs in their rooms or beds. -The residents had not reported any bug bites to her. -If she saw bedbugs or a resident told her about bedbugs, she would have reported them to the Director. Interviews with the Director on 12/11/24 at 2:58pm and 12/12/24 at 3:05pm revealed: -She did not know if bedbugs were on the pest control company's report. -She thought the last time there had been a report of bedbugs at the facility was around July 2024/August 2024. -She thought the pest control company was doing preventative treatments for bedbugs.	{D 079}		

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{D 079}	Continued From page 38 -She had not seen a live bedbug since they began treating for them in the spring or summer of 2024. -The pest control company started coming out monthly around that same time. -She checked the sofas in the common area by removing the cushions and looking for eggs and bedbugs. -She looked in the residents' rooms for eggs, movement and dark spots. -She would ask the residents if they had seen any bedbugs or if they were sleeping okay at night. -Residents had not complained of bedbugs and there had been no reports from staff. -She last looked for bedbugs about two months ago because they were no longer a problem. -She called the pest control company on 12/11/24 to set up an appointment to have resident room S8 treated, but she had not heard back from them. -The resident who resided in room S8 went out for lunch with her family today, 12/12/24; she did not inform the family the resident had bedbugs in her room. Interview with the Administrator on 12/12/24 at 8:25am revealed: -No one had reported bedbugs in the facility to him. -There had been an issue with bed bugs in the past, but they had handled it. -He and the Director inspected rooms for bedbugs when there was a report of a sighting of bedbugs. -The staff also inspected the beds for bedbugs when they changed the linen. -If there were small or large bedbugs, he would get the room treated by the pest control company. -They would cover the mattress and box springs, and wash and dry all of the bedding and clothes.	{D 079}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 079}	Continued From page 39 -He was not aware there were bedbugs in room S8; he thought the bedbugs had been resolved. -There had not been bedbugs since at least August 2024. 3. Observation of resident room NG on 12/10/24 at 8:19am revealed: -Two oxygen tanks were standing on the floor without a stand or being secured to the wall. -The two unsecured oxygen tanks were located between the resident's dresser and closet along with a rocking chair, two cases of water, two walkers, a large oxygen tank that was in a stand, and a small oxygen tank in a stand. -There was no gauge on the cylinders to indicate the remaining amount of oxygen. -There were two oxygen cylinders beside the resident's bed in a metal rack. Interview with the resident on 12/10/24 at 8:15am revealed: -No one told him how to store his oxygen tanks. -A [named] oxygen supply company had delivered the oxygen tanks and that was how the tanks were left as far as he knew. -The facility staff had not told him how to store the oxygen tanks. Telephone interview with the technician from the resident's oxygen provider on 12/11/24 at 9:52am revealed: -Oxygen tanks should always be secured to prevent the tanks from tipping over. -Oxygen tanks should be placed in a stand or chained to the wall. -If an oxygen tank fell over, it could hurt someone by injuring a body part. -If a tank were to fall and the neck broke off, it could potentially become projectile. -It was highly recommended that oxygen tanks be	{D 079}		

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{D 079}	Continued From page 40 secured using a stand or other means. Interview with a medication aide (MA) on 12/12/24 at 2:45pm revealed: -She did not do anything with the oxygen tanks. -The oxygen tanks were not her responsibility. -She was not aware they were supposed to be secured when in the facility. -She thought they did not come in when delivered in a crate or holder. -No one from management had talked to her about anything concerning oxygen tanks. Interview with a second MA on 12/13/24 at 9:04am revealed: -She did not know how oxygen tanks should be stored. -She had seen the oxygen tanks in room NG but had not noticed how the tanks were stored. Interview with the Director on 12/11/24 at 3:30pm revealed: -Oxygen tanks were supposed to be secured in stands to prevent the tank from falling over. -All staff members were responsible for ensuring oxygen tanks were secured; anyone who went in the resident's room was responsible. -She did not know there were unsecured oxygen tanks in resident room NG. -She was concerned the oxygen tanks were not secured because the tanks could fall over, knock other tanks over, and cause an explosion. Interview with the Administrator on 12/12/24 at 8:25am revealed: -He was aware oxygen tanks were supposed to be secured even if they were empty. -He was not aware some of the oxygen tanks in resident room NG were not secure. -He did not know if the oxygen tanks in room NG	{D 079}		

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{D 079}	Continued From page 41	{D 079}		

were empty or full.
-The Director was currently trying to obtain racks to secure the oxygen tanks.
-The staff should have informed the Director that the oxygen tanks were not secure.
-The Director should have discovered the unsecured tanks when she checked on residents' rooms.
-She should walk up and down the hall and look in resident rooms every day.
-He was not sure what could happen if an oxygen tank fell over when it was empty, but he was concerned a full oxygen tank could shoot across the room if it were knocked over.

4. Observation of resident room S1 on 12/10/24 at 8:10am revealed:
-There was a large amount of clothes scattered on the floor from the closet, past the dresser and to the bed; the resident was laying in the bed with miscellaneous items on the left side of the room.
-Two of the dresser's drawers were open with clothes laying over the edges and the top of the dresser was covered with miscellaneous items.
-The right side of the room had a chair with a stack of folded and unfolded clothing, a dresser with a pile of clothing and a laundry bin with a stack of folded clothes on the floor next to the foot of the bed.
-There was a full trashcan between the beds.

Observation of resident room S2 on 12/10/24 at 8:32am revealed:
-There was a large pile of clothes in a chair on the right side of the room.
-There were shoes lined up on the floor in front of the dresser.
-There multiple clothing items on top of the dresser.
-There was a tall laundry basket filled with folded

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{D 079}	Continued From page 42	{D 079}		

clothes and unfolded clothes.
-The closet and the dresser were full of clothes.

Observation of resident room S3 of the facility on 12/10/24 at 8:12am revealed there was a bed frame without a mattress and there were large clumps of dust and loose debris on the edge where the mattress would set.

Second observation of resident room S2 on 12/11/24 at 8:10am revealed:
-There was a large pile of clothes in a chair on the right side of the room.
-There were shoes lined up on the floor in front of the dresser.
-There multiple clothing items on top of the dresser.
-There was a tall laundry basket filled with folded clothes and unfolded clothes.
-The closet and the dresser were full of clothes.

Interview with the resident who resided in room S2 on 12/11/24 at 11:55am revealed:
-The staff washed his clothes and he put them away.
-His clothes were washed the day before, 12/10/24.
-He liked his clothes out where he could see them.
-His dresser and closet were full, and he did not want to get rid of any of his clothes.

Observation of resident room S4 on 12/10/24 at 8:25am revealed there was a thick layer of dust covering a long shelf and the items on the shelf above the resident's bed.

Interview with the resident who resided in room S4 on 12/10/24 at 4:50pm revealed:
-Staff did not regularly dust his room.

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{D 079}	Continued From page 43 -He thought his room could be cleaner. -He remembered his room was last dusted about two months ago. -He did not think to complain about the cleanliness of his room. Observation of resident room S5 on 12/10/24 at 8:35am revealed: -There was a dresser with a television setting on top of it there was a thick layer of dust on the dresser and the television. -There were streaks in the thick layer of dust on the dresser where objects had been moved. Interview with the two residents who resided in room S5 on 12/10/24 at 4:55pm revealed: -Staff did not clean their room. -The last housekeeper had quit about a month ago. -They noticed the dust in the room, but they did not complain to anyone because they were grateful to have a place to live. Observation of resident room S6 on 12/10/24 at 8:35am revealed: -There were multiple used and wadded up paper towels and tissues on the floor and under one of the beds in the room. -There were dried clumps of a brownish-black fecal material on the floor and a smeared area next to a bed. -There were smears of dried brownish fecal material on a plastic laundry basket next to a bed. -There was a single shoe with an empty beverage can in it on the floor at the head of the bed. -There was a large piece of clear plastic, crumpled brown card board and multiple used paper towels and tissues under the bed. -There were multiple clean adult briefs on the floor behind the headboard and next to a chair.	{D 079}		

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{D 079}	Continued From page 44 Observation of resident room S7 on 12/10/24 at 8:39am revealed: -There was a used bandage with dried blood on the floor between the bed and the nightstand. -There was a thick layer of dust on the nightstands between the beds. Observation of resident room NC on 12/11/24 at 9:00am revealed: -There were large stacks of folded clothes in both chairs of the room. -There were multiple personal items stacked on the floor around the dresser and the chairs. -There were multiple sticky boards with debris stuck to them under the beds. -There were empty plastic shopping bags loose on the floor. -There was a thick layer of dust build up on the dressers and nightstands. Interview with a resident who resided in room NC on 12/11/24 at 9:00am revealed: -The staff washed his clothes and placed them in the chair. -He would get his clothes from the chair and put them in his dresser. -His dresser was currently full. Observation of resident room NE on 12/11/24 at 9:00am revealed: -There were multiple used tissues and paper towels scattered around the room on the floor. -There was a thick layer of dust on the dresser, floor fan, and nightstands. -There were multiple items on the floor under the window including a paper bag with items in it, a bed pillow with no pillow case covered in black spots, an open tissue box, a bottle of shampoo, and a roll of toilet paper.	{D 079}		

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{D 079}	Continued From page 45 -There were miscellaneous items setting on the windowsill including two disposable red cups, three open bottles of soda with various amounts of fluid in them, a tube of lotion, an eye glass case and another small box. -There were multiple pairs of shoes, empty food packages, a roll of toilet paper and crumbs scattered on the floor. -There was a large grey plastic bag containing clothing, multiple storage bins, a short gift bag with used tissues in it, a large gift bag filled with various items including food, and two laundry baskets full of clothes in the room. -There was a small pile of bird seed and bird seed scattered around the floor. -There was a trash can that was full and had food wrappers and empty chip bags in it. -There was a spare bed with miscellaneous items including clothing that completely covered the bed. -There was a side table next to the spare bed with a sock, a disposable cup with dried liquid, two tubes of tooth paste and an eye glass holder. -The nightstand next to the resident's bed had multiple opened beverage bottles, eye glasses, lotions and other miscellaneous items; the top of the nightstand was completely covered. Observation of resident room NG on 12/11/24 at 9:14am revealed: -There was a space between the dresser and the corner of the room that had a wooden chair, blankets, reusable shopping bags that were full, various sizes of oxygen tanks, four walkers, and two cases of water bottles. -The resident had multiple personal items lined up against the wall on his bed including snacks, video cases and books. -There was a thick layer of dust on the nightstand, headboard, dresser, television and	{D 079}		

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{D 079}	Continued From page 46	{D 079}		

oxygen concentrator.
-There were clumps of dust on the dresser where someone had moved the dust off a corner of the top.

Interview with a resident who resided in room NG on 12/11/24 at 9:09am revealed:
-His room was cleaned very sporadic because the facility did not have a regular housekeeper.
-They never dusted his room; he would like to have his room dusted.
-He never told anyone to dust his room because they never had a regular housekeeper.
-When someone did clean his room they only mopped.

Interview with the housekeeper on 12/11/24 at 11:30am revealed:
-Today, 12/11/24 was her first day.
-She would dust when she did the deep cleaning.
-Some of the residents' rooms needed attention; she had noticed the clutter.
-The staff washed the residents' clothes and the residents put them away.

Interview with a personal care aide (PCA) on 12/13/24 a 9:25am revealed:
-The PCAs washed the residents' clothes and then put them in dressers and closets.
-Most residents put their own clothes away, so staff left them in their chairs.
-Some residents' dressers were too full so they left their clothes out on the chairs and dressers.
-Some residents liked to leave their clothes out and not have them put away.

Interview with a medication aide (MA) on 12/12/24 at 2:45pm revealed:
-The PCAs washed the residents' clothes and put them away.

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{D 079}	Continued From page 47 -Some of the residents did not want the staff to put their clothes away and wanted them to stay in their chairs. -Some residents wanted to put their own clothes away, so staff left them out. -Staff would ask the residents over and over again to put their clothes away and the residents would refuse. -The residents would get upset with her when she asked and asked them to put their clothes away, so she just walked away. Interview with the Director on 12/11/24 at 3:20pm revealed: -The PCAs washed the residents' clothes and put them away in the residents' closets and dresser drawers. -The Supervisor and the MAs helped to put residents' clothes away. -There were a few residents who preferred to put their own clothes away; she could name at least five. -In passing if they saw clothes were not put away, they would remind them to put their clothes away or put them away for the resident. -The residents did not have a certain amount of time to put their clothes away by. -There was one resident who would take her clothes out of her drawers and throw them around her room. -Some of the residents did not want to get rid of "stuff" or clothes and just kept adding. -She had tried to explain to residents that everything had to be in the dresser or the closet. -She told the residents the more belongings they had the more place for pest to live. -She would encourage them to get rid of old items when they got new; some of them would not listen. -She did not inspect the rooms for clutter but if	{D 079}		

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she saw it, she would try to talk to the resident.
-It would trigger behaviors with some residents when she tried to declutter or throw out items.
-The furniture was dusted weekly or as needed.
-The dusting included, dressers, any bedside tables, nightstands, nick knacks, televisions and any other furniture in the room.

Interview with the Administrator on 12/12/24 at 8:25am revealed:
-The PCA and the MAs were responsible for washing the residents' clothes and putting them away.
-If a resident requested to put their own laundry away it was okay to leave it on out unless it ended up on the floor or became part of the clutter.
-He felt it was debatable if a room was cluttered because staff would straighten the room up then go back into the room later and it would be the same way again.
-There was no remedy for the clutter; they could only ask the residents not to mess up their rooms, but it did not always work.
-Clutter was only an issue if it caused a problem; if there was no harm and no danger.
-If clutter became a trip hazard it could be harmful.
-He looked into rooms as he went up and down the halls or when staff told him it looked bad in resident's room.
-He went to a resident room last week that had clothes on the floor.
-It was hard to change residents' habits and behaviors.
-He expected the Director to walk up and down the hall and look at rooms every day.
-He did not know if she did or if she had a check list when looking at residents' rooms.

_____

The facility failed to ensure a clean and orderly

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{D 079}	Continued From page 49 environment free from obstruction and hazards related to live mice in hallways, common areas, in multiple residents' rooms, in their personal belongings and on their beds; live bedbugs in one resident's room; unsecured oxygen tanks which could injure a resident if the tanks fell; and multiple resident rooms with clutter including dust, shoes, clothes and personal belongings scattered on the floor and stored on dressers, chairs, and beds. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2025.	{D 079}		
{D 083}	10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care home shall: (9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide window coverings for two resident rooms that had blinds that were damaged and failed to provide privacy.	{D 083}		

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{D 083}	Continued From page 50 The findings are: Observation of resident room S5 on 12/10/24 at 4:55pm revealed: -There were four sets of mini blinds in the room. -Three of the four sets had multiple missing and broken slats. -The outside street and parking lot were visible from the inside of the room. Interview with the two residents who resided in room S5 on 12/10/24 at 4:55pm revealed: -The blinds had been broken for a while, they thought since they had moved into the facility. -They had not complained about the broken blinds. -They were not worried about their privacy because no one could see into their room through the broken blinds. Observations of resident room S8 on 12/12/24 at 8:17am and 10:10am revealed: -There were four windows with mini blinds on them. -There was a large section where seven slats were missing on one set of blinds. -While standing in the middle of the room the outside parking lot was clearly visible through the missing section of blinds. Interview with the resident who resided in room S8 on 12/12/24 at 10:45am revealed: -The blinds in her room had been like that for a while, she thought maybe since she had moved in. -She did not know if staff knew about the broken blinds. -She did not know if anyone could see into her room throught the blinds that were missing slats. -She left them down and closed so no one could	{D 083}		

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{D 083}	Continued From page 51 see in. -She could see out through the hole in the broken blinds. -She figured staff had not noticed the broken blinds. Interview with the Director on 12/16/24 at 11:46am revealed: -She was not aware of any broken blinds in resident rooms. -She inspected the rooms by going into them; she walked around every day. -She did not necessarily look for broken blinds she just scanned the room to see if she could see outside. -She could see lights inside the building from the parking lot at night if there were any broken blinds. -She did not know how long the blinds in S8 had been broken because the resident had not complained to her. -She had noticed a few slats were broken because she could see some light from the parking lot. -She could not see into the resident's room she only saw light from the room. -She had not noticed the multiple broken slats in the blinds in room S5, because it faced the parking lot. -The residents had not complained to her about the broken blinds in their room. -She tried to replace the broken blinds as soon as she saw them. Interview with the Administrator on 12/16/24 at 3:50pm revealed: -The Director and the staff were responsible for looking for broken blinds. -The blinds were replaced as soon as they find them broken.	{D 083}		

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{D 083}	Continued From page 52 -He did not know of any broken blinds in resident rooms; the broken blinds in rooms S5 and S8 had not been reported to him. -He expected the broken blinds to just be replaced; they did not need to be reported to him. -He only needed to be told when he needed to order more.	{D 083}		
D 087	10A NCAC 13F .0306(b)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed shall have the following: (A) at least one pillow with clean pillow case; (B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and (C) clean bedspread and other clean coverings as needed; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide a clean top and bottom sheet; change a bed soil bed pad and pillow cases on residents' beds in resident rooms S4, S6, and S7.	D 087		

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	HAL073010	A. BUILDING: _____ B. WING _____	R 12/17/2024

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MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 087	Continued From page 53 The findings are: Observation of resident room S4 on 12/10/24 at 8:25am revealed: -There was a mattress cover with multiple black spots in the corners and no bedsheets on the bed. -There was a disposable bed pad with a large wet spot and debris on it. -There was a pillow with no pillow case on one of the resident's beds. Observations of resident room S4 on 12/11/24 at 8:10am and on 12/12/24 at 10:25am revealed: -There was a mattress cover with multiple black spots in the corners and no bedsheets on the bed. -There was a disposable bed pad with a large dried urine spot and debris on it. -There was a pillow with no pillow case on one of the resident's beds that was soiled and blackish where the resident's head would rest. Interview with a resident who resided in room S4 on 12/12/24 at 10:25am revealed: -His bedsheets were changed about once a month. -His bed had not had a bottom bedsheet on it for about a month. -The staff did not make his bed. -The disposable mattress pad was not changed when it was dirty; it would be left on for several days. -He thought the facility was being "skimpy" with the pads because he was running low on them. -He did not complain to anyone, he just slept on the bed. -He would like to have a bottom sheet and have his bed made up.	D 087		

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D 087	Continued From page 54 Observation of resident room S6 on 12/10/24 at 8:35am revealed: -There was a bed with a only a sheet on it and various miscellaneous items stacked on the bed including a toilet paper that stretched out the length of the bed and was balled up in sections. -There was a large dried brownish drip and smear of material on the corner of the mattress at the foot of the bed. Observation of resident room S7 on 12/10/24 at 8:40am and on 12/11/24 at 8:11am revealed: -There was a bed with a mattress cover but no bedsheet and there were miscellaneous items scattered on the bed. -There was debris and a cigarette butt on the bed. -There was a large circle and smear of dried brownish-black material on the bottom of the mattress cover near the footboard. -There was a second bed that was unmade, there was a large dried circle and a fresh wet circle of the same size on the bottom sheet. Interview with the resident who resided in room S7 on 12/11/24 at 11:45am revealed: -Staff changed his bed about once a month. -He had not noticed anything wrong with his sheets. -His bed was not made every day; sometimes he went back to bed after he ate breakfast. -He did not have a roommate because he went to the hospital. -The other bed in his room had looked like that; "all messed up" since his roommate left over a month ago. Telephone interview with a resident's family member on 12/16/24 at 10:35am revealed she took her family member home over the	D 087		

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D 087	Continued From page 55 Thanksgiving holiday and when she returned to the facility, the resident's bed was left unmade, and when she returned several days later, the resident's bed was just like it was left. Interview with a personal care aide (PCA) on 12/13/24 a 9:25am revealed: -The PCA changed the sheets every other day or if they were dirty from the night before. -The residents' beds were made everyday unless they were sleeping in them. -The bed pads were supposed to be changed everyday when the bed was made up. -The beds were supposed to have a bottom sheet, a top flat sheet and a comforter or bedspread. -She had not noticed any soiled beds or bed pads that had not been changed. -She changed the soiled sheets when she saw them. Interview with a medication aide (MA) on 12/12/24 at 2:45pm revealed: -She did not change sheets or make beds, becausethe PCAs did that. -She did not help or "work on the floor like that". -She had not noticed soiled beds or unmade beds. -Only one resident had a bed pad and she was on the North hall. -She did not know the resident residing in room S4 had a bed pad. -She only turned the light on and opened the door to the room and the residents came to her to take their medications; she did not go into their rooms. Interview with the Director on 12/11/24 at 2:58pm revealed: -The beds were made everyday by the PCAs. -The sheets were changed every other day or as	D 087		

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D 087	Continued From page 56 needed. Interview with the Administrator on 12/12/24 at 8:25am revealed: -He did not know the schedule for changing the resident's sheets. -The sheets should be changed weekly unless more frequently if someone soiled the bed. -Every bed should have a bottom sheet, a top sheet, pillows with a pillow case and a blanket. -Bed pads should be changed every morning even if they were not soiled. -All staff washed and changed sheets. -The Director should have been inspecting rooms every day by walking up and down the hall and looking in resident rooms.	D 087		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled staff (Staff A, B) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are:	D 137		

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D 137	Continued From page 57 1. Review of Staff A's, housekeeper and cook, personnel record revealed: -Staff A was hired on 12/03/24. -There was no documentation an HCPR check was completed prior to or upon hire. -There was an HCPR check completed on 12/16/24 with no pending or substantiated findings. Interview with Staff A on 12/16/24 at 5:07pm revealed: -She started working at the facility on 12/02/24. -She had worked at the facility about two years ago as a medication aide (MA). -She did not know if an HCPR check had been done yet. -She thought there might be finding on the HCPR check because she was removed from the schedule at the previous assisted living (AL) facility she worked. -She was under investigation for drug diversion and falsifying resident information. -She had a pending court date for January 2025 for the accusations of drug diversion. -The last time she worked at the previous AL was July of 2024. Interview with the Supervisor on 12/16/24 at 5:20pm revealed she had not had a chance to go through Staff A's personnel record to see if everything was there. Interview with the Director on 12/16/24 at 6:12pm revealed: -She was responsible for the hiring of new staff and completing paperwork. -She did the interviews and then told the Administrator about the interview. -She checked references and did the HCPR check after the staff was interviewed.	D 137		

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D 137	Continued From page 58 -Staff A started about two weeks ago. -She knew the HCPR check was required before she could hire staff. -She did not check Staff A's references, but she checked her HCPR the week before she was hired. -She did not see any findings on Staff A's HCPR check so she hired her. -She could not find the HCPR check she ran for Staff A in her personnel record. Refer to the interview with the Supervisor on 12/16/24 at 5:20pm. Refer to the interview with the Administrator on 12/17/24 at 11:34am. 2. Review of Staff B's, cook and personal care aide (PCA), personnel record revealed: -She was hired as a cook/PCA on 05/02/24. -There was no documentation an HCPR check was completed prior to or upon hire. -There was an HCPR check completed on 12/16/24 with no substantiated findings. Telephone interview with Staff B on 12/17/24 at 9:54am revealed: -She was not sure what a HCPR check was. -She was not sure if one was done. -She started working at the facility as a cook in the spring. -She could work as a PCA, but she just worked as the cook. -There would be no findings on her HCPR check. Interview with the Supervisor on 12/16/24 at 5:20pm revealed: -She had not had a chance to go through Staff B's personnel record yet. -She did not recall when Staff B was hired.	D 137		

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D 137	Continued From page 59 Interview with the Director on 12/16/24 at 6:12pm revealed: -Staff B was hired in October 2024. -She had done a HCPR check on Staff B prior to her being hired. -She knew the HCPR check was required before she could hire staff. -She thought she had put a printout of the HCPR check in the personnel record. -There were no findings on Staff B's HCPR check. Refer to the interview with the Supervisor on 12/16/24 at 5:20pm. Refer to the interview with the Administrator on 12/17/24 at 11:34am. _____ Interview with the Supervisor on 12/16/24 at 5:20pm revealed: -She was responsible for going through the staff [personnel] records to make sure all hire documents were in them. -She used a check list and checked after the staff was hired. -She was not responsible for doing HCPR checks; the Director was responsible for the HCPR checks. -If something was missing from the personnel record, she let the Director know. Telephone interview with the Administrator on 12/17/24 at 11:34am revealed: -The Director was responsible for completing the HCPR checks prior to interviewing for staff positions. -The Director knew the HCPR checks were to be done prior to interviewing and not after hire. -The Director audited the personnel records to	D 137		

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D 137	Continued From page 60 make sure they were complete. -He was not responsible for the personnel records. -He was not aware the HCPR checks for the newly hired staff were not done. -He expected the HCPR checks to be done before the interviews, so time was not wasted on an interview. _____ The facility failed to ensure 2 of 5 sampled staff (A and B) had Healthcare Personnel Registry checks with no substaniated or pending findings prior to beginning work at the facility . This failure was detrimental to the health, safety, and welfare of all the residents who resided in the facility and constituted a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/16/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2025.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled staff (Staff A) had a criminal background check completed	D 139		

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D 139	Continued From page 61 upon hire. The findings are: Review of Staff A's, housekeeper and cook, personnel record revealed: -Staff A was hired on 12/03/24. -There was no documentation a criminal background check completed prior to or upon hire. Interview with Staff A on 12/16/24 at 5:07pm revealed: -She started working at the facility on 12/02/24. -She had worked at the facility about two years ago as a medication aide (MA). -She did not know if a criminal background check had been done; she signed a consent to check after she was hired. Interview with the Supervisor on 12/16/24 at 5:20pm revealed: -She was responsible for going through the personnel records to make sure all new hire documents were in them. -She had not had a chance to go through Staff A's personnel record to see if everything was there. -She used a check list and checked the personnel record after the staff was hired. -She was not responsible for doing criminal background checks; the Director was responsible for the checks. -If something was missing from the personnel record, she let the Director know. Interview with the Director on 12/16/24 at 6:12pm revealed: -She was responsible for the hiring of new staff and completing paperwork. -She did the interviews and told the Administrator	D 139		

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D 139	Continued From page 62 about the interview. -She checked references and did the criminal background check after the staff was interviewed. -Staff A started about two weeks ago. -She knew the criminal background check was required before she could hire staff. -She mailed a request for Staff A's criminal background check to the federal agency the facility used for criminal background checks about a week ago. -It usually took about three to four weeks for the report to come back. -She had always used a mail in service for a criminal background check for staff. Telephone interview with the Administrator on 12/17/24 at 11:34am revealed: -The Director was responsible for completing the criminal background checks. -The Director mailed the criminal background check to the state bureau of investigations. -The Director knew the criminal background checks were supposed to be done prior to hire and not after hire. -Most of the criminal background checks were done prior to hiring staff, but some were returned after hiring due to the mail. -The Director audited the personnel records to make sure they were complete. -He was not responsible for the personnel records. -He was not aware the criminal background check for Staff A was not done. -He expected the criminal background checks to be done before hire.	D 139		
D 176	10A NCAC 13F .0601 (a) Management of Facilities-General Administrato	D 176		

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D 176	Continued From page 63 10A NCAC 13F .0601 Management Of Facilities - General Administrator And Manager Responsibilities (a) Each adult care home shall have an administrator who is certified in accordance with Rule .1701 of this Subchapter. The administrator shall be responsible for the total operation and management of the facility to assure that all care and services are provided to maintain the health, safety, and welfare of the residents in accordance with all applicable local, state, and federal regulations and codes. The administrator shall also be responsible to the Division of Health Service Regulation and the county department of social services for complying with the rules of this Subchapter. The co administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term "administrator" also refers to co administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the management and overall operations of the facility by failing to meet and monitor rules related to medication administration, health care,	D 176		

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D 176	Continued From page 64 housekeeping and furnishings, infection prevention and control, resident rights, staff qualifications and health care personnel registry. The findings are: Confidential interview with a resident revealed: -The Administrator came to the facility "every blue moon." -He could not recall the last time he had seen the Administrator Confidential interview with a second resident: -The Administrator was at the facility every three weeks to a month. -The Administrator was not at the facility every week. Interview with a resident on 12/13/24 at 9:10am revealed: -The Administrator visited the facility about once a week. -Sometimes he stayed in the office and sometimes he walked around. -When he walked around, he would ask if everything was "good" or if the residents were having a good day. -If a resident needed to speak to the Administrator they could go to the office when he visited. Interview with the Director on 12/10/24 at 4:37pm revealed: -The Administrator was at the facility once a week. -The Administrator walked around the facility and talked to the residents when he was at the facility. Interview with a medication aide (MA) on 12/13/24 at 9:04am revealed:	D 176		

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D 176	Continued From page 65 -The Administrator was at the facility once a week for "hours." -The Administrator walked around the facility when he was there. Interview with the Supervisor on 12/16/24 at 11:42am revealed: -The Administrator was at the facility as often as he needed to be. -Sometimes the Administrator was at the facility a couple of days a week. -She did not know what the Administrator did while he was at the facility. Interview with the Administrator on 12/12/24 at 8:25am revealed: -He expected the Director to walk up and down the hall and look at rooms every day. -He did not know if she did or if she had a check list when looking at residents' rooms. -The Director was responsible for reviewing the housekeeping logs every day to make sure everything was done. Interview with the Administrator on 12/16/24 at 3:40pm, 4:20pm, and 5:49pm revealed: -He asked the Director if everything was done, and she would tell him if there was an issue. -He did not look at the kitchen cleaning logs. -He looked at the kitchen to see if it was clean at least once a week. -He looked at the kitchen and the floors; he looked at the overall condition of the kitchen. -He would tell the kitchen staff and the Director if he saw something that needed attention. -The last time he looked at the kitchen was the week before last; the floors needed to be cleaned so he told the kitchen staff. -He expected the Director to make sure the sanitation in the kitchen was maintained.	D 176		

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D 176	Continued From page 66	D 176		

-He was not aware of any door alarms not working.
-Staff had reported sometimes if the front door was not closed, the alarm would continuously sound.
-He was not aware the alarm on the south hallway exit door was not working.
-He was not aware the alarm on the north hallway exit door would not sound at times when the door was opened.
-He was at the facility 2-3 days per week.
-He made sure the Director was doing what needed to be done by asking questions.
-He asked questions of the Director such as are the medications in the facility, had cart audits been conducted, and the response was always yes.
-"Maybe he should do more."

Telephone interview with the Administrator on 12/17/24 at 11:34am and 2:42pm revealed:
-He did not do audits of the personnel records.
-He was not responsible for the personnel records.
-The Director was completely responsible for the personnel records.
-The Director was responsible for completing the HCPR checks prior to interviewing for staff positions.
-The Director should check when medications were delivered to the facility to ensure all ordered medications were delivered.
-The Director should check the medication cart bi-weekly to make sure all medications were on hand to be administered.
-The Director needed to audit the eMAR when doing the cart audits.
-He was concerned that it did not appear this process was being done, or not consistently because missed medications would not be an

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D 176	Continued From page 67 issue. Non-compliance was identified in the following rule areas: 1. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 9 of 9 sampled residents (#1, #2, #3, #6, #7, #8, #9, #11 and #13) including two blood pressure (BP) medications (#1); a BP medication (#2); two medications for BP and a medication for mood stabilizing (#3); an inhaler (#6); a medication for tremors (#7); an inhaler and a topical pain medication (#8); two inhalers (#9); a medication for seizures and a medication for mood stabilizing (#11); and a BP medication (#13). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type Unabated A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to follow the Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 4 of 4 sampled diabetic residents (#1, #3, #5 and #6) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents.[Refer to Tag D0611, 10A NCAC 13F .1801(b) Infection Prevention & Control Policies and Procedures (Type Unabated B Violation)]. 3. Based on interviews and record reviews, the facility failed to maintain an environment in which the residents were protected from physical and verbal abuse as evidenced by Staff B and C hitting a resident (#10), Staff B and D cursing at multiple residents, Resident #7 being hit by staff, multiple residents sprayed with water by staff members; and 1 of 1 sampled resident (#11) who	D 176		

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was denied a reasonable response when he requested a roommate change when the roommate displayed sexual behaviors and poor hygiene. [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)].

4. Based on observations, interviews and record reviews, the facility failed to immediately coordinate with a new primary care provider (PCP) in a timely manner for 21 of 22 residents after the previous PCP had provided a 30-day notice to the facility of the termination of physician services. [Refer to Tag 277 10A NCAC 13F .0902(d) Health Care (Type A2 Violation)].

5. Based on observations, interviews, and record reviews, the facility failed to provide a clean and orderly environment free from obstructions and hazards related to the presence of live mice, live bedbugs, unsecured oxygen tanks in a resident's room, and clutter in multiple residents' rooms. [Refer to Tag D079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].

6. Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled staff (Staff A, B) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. [Refer to Tag D0137, 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type B Violation)].

7. Based on observations, record reviews, and interviews, the facility failed to implement physician's orders for 5 of 5 sampled residents (#1, #3, #5, #6 and #7) related to blood pressure checks (#1); finger stick blood sugars checks (#1, #3, #5, #6 and #7); and weekly weights (#3). [Refer to Tag 276 10A NCAC 13F .0902(c) 3-4

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D 176	Continued From page 69 Health Care (Type B Violation)]. 8. Based on observations, interviews, and record reviews, the facility failed to ensure three exit doors had a sounding device that was audible throughout the facility when the doors were opened which was accessible to five residents (#3, #7, #8, #10, #12) who were identified as disoriented. [Refer to Tag D067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]. 9. Based on record reviews and interviews, the facility failed to complete Health Care Personnel Registry (HCPR) reports for alleged verbal and physical abuse by Staff B, Staff C, and Staff D toward multiple residents who were hit, cursed at, and sprayed with water. [Refer to Tag 438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)]. 10. Based on observations, interviews, and record reviews, the facility failed to provide personal care to 1 of 3 sampled residents (#8) related to toenails that needed to be trimmed. [Refer to Tag D0269, 10A NCAC 13F .0901(a) Personal Care and Supervision TYPE B VIOLATION)]. 11. Based on observations, interviews, and record reviews, the facility failed to ensure the floors, doors, baseboards, window blinds and window sills were kept clean and in good repair in the hallway and in resident rooms S2, S3, S4, S5, S7, NC and NE. [Refer to Tag D074, 10A NCAC 13F. 0306(a)(1) Housekeeping and Furnishings (standard deficiency)]. 12. Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled staff (Staff	D 176		

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D 176	Continued From page 70 A) had a criminal background check completed upon hire. [Refer to Tag D0139, 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (standard deficiency)]. 13. Based on record review and interviews, the facility failed to ensure 1 of 3 sampled residents (#1) was tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services. [Refer to Tag D0234, 10A NCAC 13F .0703(a)Tuberculosis Test, Medical Exam & Immunizations (standard deficiency)]. 14. Based on observations, record reviews, and interviews, the facility failed to provide window coverings for privacy for resident rooms that had blinds that were damaged. [Refer to Tag D083, 10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings (standard deficiency)]. 15. Based on observations and interviews, the facility failed to provide a clean top and bottom sheet; change a bed soil bed pad and pillow cases on residents' beds in resident rooms S4, S6, and S7. [Refer to Tag D087, 10A NCAC 13F .0306(b)(1) Housekeeping And Furnishings (standard deficiency)]. 16. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 1 sampled residents (#4) who demonstrated the need for increased supervision related to smoking in his room. [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (standard deficiency)]. 17. Based on observations, record reviews and interviews, the facility failed to ensure all food items stored and prepared by the facility were	D 176		

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served under sanitary conditions related to a dirty food storage and preparation area windowsills, rodent droppings on shelves and floors in the dry storage area; and dirty floors in the kitchen. [Refer to Tag D0283, 10A NCAC 13F .0904(a)(2) Nutrition and Food Service (standard deficiency)].

18. Based on observations, record reviews, and interviews, the facility failed to ensure that 8 ounces of milk or other equivalent of dairy servings were served three times daily to the residents. [Refer to Tag D0299, 10A NCAC 13F .0904(d)(3) Nutrition and Food Service (standard deficiency)].

19. Based on observations, interviews, and record reviews, the facility failed to serve supplements as ordered for 1 of 1 sampled resident (#8) who had an order for a nutritional supplement. [Refer to Tag D0310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (standard deficiency)].

20. Based on observations, record reviews, and interviews, the facility failed to ensure contact with the resident's prescribing practitioner for clarification of medication orders for 3 of 4 sampled residents (#2, #3, #5) including an antibiotic, two supplements, eye drops, nasal spray, a stool softener, and an anti-itch lotion (#2), a stool softener (#3). [Refer to Tag D0344, 10A NCAC 13F .1002(a) Medication Orders (standard deficiency)].

21. Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration record (MAR) was accurate for 8 of 9 sampled residents (#1, #2, #3, #5, #6, #7, #8, #9) including the administration of an insulin (#1); a pain medication (#2); an insulin

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D 176	Continued From page 72 (#3), two insulins, an anti-anxiety medication, and a blood pressure medication (#5); an insulin, an inhaler and a blood pressure medication (#6); a cholesterol medication and a medication for abnormal movements (#7); a pain medication (#8); and a sleep aid (#9). [Refer to Tag D0367, 10A NCAC 13F .1004(j) Medication Administration (standard deficiency)]. 22. Based Based on observations, interviews, and record reviews, the facility failed to ensure medications left on top of a medication cart were locked when not under the direct physical supervision of a medication aide. [Refer to Tag D0378, 10A NCAC 13F .1006(b Medication Storage (standard deficiency)]. 23. Based on record reviews and interviews, the facility failed to maintain a record of each transaction involving the use of the residents' personal funds was signed by the resident, legal representative, or payee or marked by the resident, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds and maintained for sampled for 4 of 4 sampled residents (#3, #6, #9, #14). (#3, #6, #9, #14). [Refer to Tag D0419, 10A NCAC 13F .1104 (a Accounting For Resident's Personal Funds (standard deficiency)]. 24. Based on record review and interviews, the facility failed to notify the County Department of Social Services (DSS) of an incident/accident that required emergency medical evaluation for 2 of 2 residents (#1 and #7) who had multiple falls with injury (#1) and a laceration caused by a fall (#7). [Refer to Tag D0451, 10A NCAC 13F .1212(a) Reporting of Accidents and Incidents (standard deficiency)].	D 176		

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D 176	Continued From page 73 The Administrator failed to ensure that the management, operations, and policies of the facility were implemented to ensure the services necessary to maintain the resident's physical and mental health were provided as evidenced by the failure to maintain compliance with the rules governing adult care homes, which was the responsibility of the Administrator. This failure included ensuring medications were administered as ordered to 9 residents; infection control procedures not being followed and residents' glucometers being shared; housekeeping was not being maintained resulting in bed bugs and mice being observed, as well as the overall cleanliness of the facility and contamination in the kitchen; door alarms were not being monitored for five residents who had been identified as disoriented; residents reported being cursed at and hit by staff members; blood pressure monitoring and finger stick blood sugar checks were not being done as ordered for 4 residents; no primary care provider (PCP) was available for refills on residents' medications after a 30-day notice had been given on 10/31/24 by the PCP that services were being discontinued; and the HCPR was not notified of staff who had allegations of hitting and cursing at the residents. This failure resulted in serious harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/24. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 16, 2025.	D 176		
{D 234}	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio	{D 234}		

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{D 234}	Continued From page 74 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 3 sampled residents (#1) was tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #1's current FL-2 dated 11/05/24 revealed diagnoses included multiple falls, gait instability, diabetes mellitus type 2 with hyperglycemia, hypertension, and hyperlipidemia. Review of Resident #1's Resident Register revealed an admission dated of 02/21/23. Review of Resident #1's immunization record revealed: -There was a TB test administered on 10/15/24 and read on 10/17/24; the results were read as 0mm. -There was not a second TB test available for	{D 234}		

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{D 234}	Continued From page 75 review. Telephone interview with Resident #1's previous primary care provider (PCP) on 12/11/24 at 5:21pm revealed: -She did not administer TB skin tests. -She did not have a record of a TB test for Resident #1. -Resident #1 should have been tested for TB prior to being admitted to the facility. -If Resident #1 was positive for TB, he could easily infect other residents in the facility. Interview with the Director on 12/11/24 at 9:20am revealed: -She was responsible for making sure the residents' two step TB tests were completed and the results documented in their records. -She did random audits on the records and checked for TB results. -The TB results were easy to look for because they had their own tab in the record. -She had begun an audit in late September 2024, but she had not finished it; she still had about 10 to 11 resident records to finish auditing. -She had looked for the residents who needed their first step TB done. -She created a spreadsheet with the residents' names, so she knew Resident #1 had one TB done. -Resident #1 had a TB test done in October 2024 by the registered nurse (RN), who gave the test and then read the results. -Resident #1 already had his first step done so the TB test done in October 2024 was his second step. -Multiple residents had their TB test done in October 2024 by the RN. -When the RN read the TB results, she documented all the residents' readings on one	{D 234}		

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{D 234}	Continued From page 76 sheet of paper and signed it. -She could not find the paper with the TB results documented on them; one of the staff had moved it. Interview with the Administrator on 12/16/24 at 4:20pm revealed: -The Director was responsible for ensuring residents' TB tests were done. -She was responsible for making sure they were documented and in the residents' records. -He asked her if everything was done and she would tell him if there was an issue. -There should not have been an issue with TB tests and results; they should have been done. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	{D 234}		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care to 1 of 3 sampled residents (#8) related to toenails that needed to be trimmed.	D 269		

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D 269	Continued From page 77 The findings are: Review of Resident #8's most recent FL-2 dated 11/08/23 revealed diagnoses included metabolic encephalopathy, asthma, dementia, muscle weakness and constipation. Review of Resident #8's Care Plan dated 11/10/23 revealed Resident #8 required limited assistance with grooming and personal hygiene. Observation of Resident #8's toenails on 12/16/24 at 11:00am revealed: -The resident's first toenail on his right foot was thick, rough edged, and turned upward one inch. -The second, third, and fourth toenails on the right foot extended past the end of the toes one-fourth of an inch. -The third and fourth toenails on his right foot were rough edged. -The resident's second toenail on his left foot had grown over the top of the toe and was turned underneath the toe toward the skin. -The third and fourth toenails on the left foot extended past the end of the toes one-fourth of an inch. Interview with Resident #8 on 12/16/24 at 11:00am revealed: -Her toenail was turned up on her big toe. -It hurt sometimes when she wore her shoes. -She had not seen a doctor to have her toenails cut. Interview with Resident #8's family member on 12/16/24 at 11:30am revealed: -Resident #8's toes nails were "messed up". -Resident #8 told her, her feet hurt. -Resident #8's toenails were growing into her skin.	D 269		

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-She tried to cut Resident #8's toenails but she could not.
-She told the Director about Resident #8's toenails and asked the Director to make Resident #8 an appointment with a Podiatrist; she would take Resident #8 to the appointment.
-She did not remember when she asked the Director to make an appointment for Resident #8.
-She had asked the Director several times about making an appointment for Resident #8.

Interview with a personal care aide (PCA)on 12/16/24 at 10:56am revealed:
-She and the Supervisor assisted Resident #8 with her shower this morning.
-She did not notice Resident #8's toenails being too long.
-She did not cut residents' toenails.
-She thought the medication aides (MA) cut the resident's toenails.

Interview with a MA on 12/17/24 at 11:15am revealed:
-She had not noticed Resident #8's toenails.
-Resident #8 did not complain to her about her toes or feet hurting.
-Resident #8's family member had not said anything to her about Resident #8's toenails needing to be trimmed.
-She did not cut toenails.
-The Podiatrist would come to the facility to cut the resident's toenails.

Interview with the Supervisor on 12/16/24 at 11:41am revealed:
-No one had said anything to her about Resident #8's toenails.
-She assisted with Resident #8's shower this morning, but did not notice her toenails.
-She did not know if the Podiatrist had attempted

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D 269	Continued From page 79 to cut her toenails when he visited. -She did not cut toenails in the facility. -She did not know who was responsible for cutting toenails for non-diabetic residents. Interview with the Director on 12/16/24 at 5:03pm revealed: -The MAs and PCAs should trim non-diabetic, residents' toenails. -Nobody had mentioned to her that Resident #8's toenails needed to be trimmed. -The toenails could grow into her skin and cause a sore. -It had to be painful when Resident #8 put on her shoes. Telephone interview with the Administrator on 12/17/24 at 2:53pm revealed: -Someone should have reported to the Director about the shape of Resident #8's toenails. -The Podiatrist could see Resident #8. -Since Resident #8 was not a diabetic, the staff should be able to cut her toenails. -Resident #8 could not be comfortable with her toenails long and growing into her skin. -Resident #8 had a potential for skin infections with the toenails growing into her skin. _____ The facility's failed to provide nail care to Resident #8 resulting in long and jaggered toenails, with one toenail that extended over the end of the toe, underneath the toe toward the skin that caused pain when ambulating with shoes and with the potential to cause skin breakdown. This failure was detrimental to the health and safety of the resident, and constitutes a Type B Violation. _____ The facility provided a plan of protection 01/03/25.	D 269		

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D 269	Continued From page 80 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2025.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 1 sampled residents (#4) who demonstrated the need for increased supervision related to smoking in his room The findings are: Review of the facility's Smoking Policy dated 09/03/14 revealed: -Residents who smoked must use the designated smoking areas. -No smoking was allowed in the residents' bedrooms. -Staff would supervise residents who smoked as needed. -The facility reserved the right to confiscate all smoking material if the resident failed to abide by smoking policies which included smoking in designated areas and during designated times to ensure fire safety for themselves or other	D 270		

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D 270	Continued From page 81	D 270		

residents.
-Smoking hours were from 7:00 AM to 9:00 PM.
-All residents who the facility managed their cigarettes would receive one cigarette every two hours.

Review of Resident #4's current FL-2 dated 11/06/23 revealed diagnoses included schizoaffective disorder and paranoid personality disorder.

Observation of Resident #4's bedroom S2 on 12/11/24 at 8:10am revealed:
-There were no residents in the room.
-There was a strong smell of cigarette smoke in the room.
-There were two windows in the room.
-The first widow next to the left bed was closed and there was a screen in the window.
-The second window next to th bed on the right side of the room was open 3 inches; the screen was missing from the window.
-There where three yellow nicotine stains with small black marks in the middle of each stain on the windowsill of the second window.
-There were black ashes on the brick edge on the outside of the second window.
-There were ashes and a cigarette butt inside the sash of the second window.
-There was a lighter and an open cigarette package on the nightstand in front of the open window.
-The resident who resided in the room returned to the room and closed the window after cleaning off the ashes and the cigarette butt.
-The resident used hand sanitizer to attempt to remove the yellow stains and black marks from the windowsill.

Observation of Resident #4's bedroom on

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D 270	Continued From page 82 12/12/24 at 9:10am revealed: -There was a strong smell of cigarette smoke in the room. -There was a one-third inch section of round cigarette ashes on the floor beside the foot of Resident #4's bed. Review of Resident #4's Resident Agreement dated 07/09/19 revealed: -The smoking policy was not signed by Resident #4; someone else had signed for him and it was not dated. -The policy had been amended on 09/03/14. -The policy for use of tobacco was under the house rules. -Residents who smoked must use the designated smoking areas. -No smoking was allowed in the residence bedrooms. Interview with Resident #4 On 12/11/24 at 8:35am revealed: -He resided in resident bedroom S2. -He smoked cigarettes. -He never smoked in his room. -He was not allowed to smoke in his room. -He only smoked where he was supposed to smoke; outside on the side porch. -His room smelled like cigarette smoke because he smoked and it [the smell] was on his clothes. -Sometimes he put cigarettes butts back into the cigarette package and brought them inside to throw away. -He also brought a named resident's cigarette butts inside to throw away; he also put those cigarette butts into his cigarette package. -There were cigarette butts on the windowsill because when he brought the cigarette butts inside and threw the them out the window. -There were no ashes on the windowsill, it was	D 270		

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just dust.
-The marks and stains on the windowsill where there when he moved into the room.
-He took the other residents' cigarette butts to help them out.
-There was a place outside on the porch to throw away cigarette butts away.
-He did not know why he did not throw away the butts while he was outside.

Interview with Resident #4's roommate on 12/11/24 at 8:36am revealed he had never seen his roommate smoking in the room.

Interview with a resident on 12/11/24 at 11:55am revealed:
-He smoked and smoked with Resident #4 in the smoking area.
-Resident #4 was caught smoking in his room two times by staff.
-Resident #4 took cigarette butts from other residents and finished smoking them later.
-Resident #4 said his clothes smelled like cigarette smoke and that was where the smell was coming from.

Interview with a personal care aide (PCA) on 12/11/24 at 8:45am revealed:
-She never smelled smoke in Resident #4's room.
-She had not noticed the open window when she was in his room that morning.
-She thought both the residents who resided in resident bedroom N2 smoked.

Interview with a second PCA on 12/11/24 at 7:00pm revealed:
-Resident #4 tried to sneak outside to smoke after smoking hours.
-He would leave the door cracked just a little so

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the alarm would not sound.
-She had not caught him smoking in his room, but she had smelled a strong smell of cigarette smoke in his room before.
-She had questioned him when she smelled the cigarette smoke, but he told her he did not smoke in his room.
-He picked up cigarette butts while outside to smoke them later.
-She tried to get the cigarette butts away from him when she knew he had them.

Interview with a medication aide (MA) on 12/13/24 at 9:35am revealed:
-She had not caught Resident #4 smoking in his room, but she wondered if he did because she could smell the cigarette smoke.
-She smoked and when she could not finish a cigarette, she would extinguish it and leave the "short butt" outside; if Resident #4 went outside after she smoked the short butt would disappear.
-She had asked him about the cigarette butts she left, and he would deny taking them and say he threw it away.
-He would not answer her when she asked him why he threw it away.
-He told her he brought the cigarette butts inside the facility and flushed them.
-The residents were not allowed to keep any form of cigarettes in their rooms, including cigarette butts.
-Residents were issued cigarettes at scheduled smoking times.
-She had not seen ashes in his room or the window open.
-She had not reported any of her suspicions to anyone because she had not seen him do anything.
-The residents were not allowed to smoke inside the facility.

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D 270	Continued From page 85 Interview with the Supervisor on 12/16/24 at 11:30am revealed: -Residents were not allowed to smoke inside the facility. -Resident #4's room smelled like cigarette smoke at times. -He denied smoking in his room. -The smell of cigarette smoke in his room was stronger than just his clothes like he claimed. -She had not looked in his room for cigarettes or ashes. -She had not noticed the missing window screen or the opened window. -She thought at one time the Administrator had spoken to Resident #4 about not smoking in his room. Interview with the Director on 12/11/24 at 8:40am revealed: -She had smelled cigarette smoke in Resident #4's room. -She had never seen Resident #4 smoking in his room. -She suspected he was smoking in his room because she could smell it but, she had never caught him smoking. -She questioned him about it sometime in August 2024, but he denied smoking in his room. -Staff said they could smell smoke in his room; they had not said it was at any certain time of the day. -She had given Resident #4 a verbal warning about smoking in his room in August 2024 when she questioned him about the smell. -Residents could smoke on the side porches of the facility at scheduled times from 8:00am to 6:00pm. -Residents were not allowed to keep cigarettes at any time; the staff gave residents their cigarettes	D 270		

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D 270	Continued From page 86 at the scheduled smoking times. Interview with the Administrator on 12/12/24 at 9:10am revealed: -He thought Resident #4 was smoking in his room. -He could smell the cigarette smoke in Resident #4's room. -He saw the ashes on the floor at the foot of his bed on 12/12/24. -He saw the screen on the window had been removed; probably because Resident #4 was throwing the butts out the window when he smoked in his room. -Resident #4 denied smoking in his room when asked. -Smoking was not allowed in the facility. -The residents had to smoke outside and were not allowed to have cigarettes on them. -He spoke to Resident #4 about not smoking in his room today, 12/12/24.	D 270		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE A2 VIOLATION The Type A2 Violation was abated, Non-compliance continues.	{D 276}		

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{D 276}	Continued From page 87 THIS IS A TYPE B VIOLATION. Based on observations, record reviews, and interviews, the facility failed to implement physician's orders for 5 of 5 sampled residents (#1, #3, #5, #6 and #7) related to blood pressure checks (#1); finger stick blood sugars checks (#1, #3, #5, #6 and #7); and weekly weights (#3). The findings are: 1. Review of Resident #3's current FL-2 dated 11/06/23 revealed diagnoses included schizophrenia, mild retardation, diabetes mellitus type 2, and hypertension. a. Review of Resident #3's physician's order dated 10/22/24 revealed: -There was an order for weekly weights, document on the medication administration record (MAR). -Encourage [resident] to switch to diet soda rather than sugary sodas and drinks. Review of Resident #3's MAR for October 2024 revealed: -There was a handwritten entry for weekly weights, document on the MAR, scheduled at 8:00am. -There was a long arrow drawn through the dates 10/01/24 to 10/23/24. -There was nothing else documented on the MAR entry. Review of Resident #3's November 2024 and December 2024 electronic medication administration record (eMAR) revealed there was not an entry for weekly weights.	{D 276}		

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{D 276}	Continued From page 88 Review of Resident #3's monthly weight log from January 2024 to November 2024 revealed: -The log was for one year. -The log had five columns; the first column was for each month, the second for documenting the weight, the third the pounds lost or gained within one month, the fourth for pounds lost or gained within 6 months and the fifth for percentage of weight lost or gained. -The instructions on the bottom of the log instructed to indicate a plus for weight gain and a minus for weight loss. -There were instructions to determine the amount of weight loss by dividing the number of pounds gained or lost by the previous weight. -Resident #3 was documented as weighing 260 pounds in January 2024 and 248 pounds in October and November 2024. -Based on his documented weight on the weight log Resident #3 had a 3 percent weight loss from November 2024 to 12/12/24. -There was no date documented to indicate what day of the month the weights were taken and there was only one date per month. Observation of Resident #3 on 12/12/24 at 10:52am revealed: -He was taken to a storage room and weighed by the Director and the Supervisor in a weight chair. -His weight was 241 pounds. Telephone interview with Resident #3's former primary care provider (PCP) on 12/12/24 at 1:05pm revealed: -Resident #3 was ordered weekly weights because he had gained weight due to a medication he was ordered. -There were no parameters with Resident #3's weekly weight order. -Some of his other medications might need to be	{D 276}		

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{D 276}	Continued From page 89 changed due to his weight gain. -He was encouraged to cut back on his sugary sodas and to hopefully have some weight loss. -His weight was a concern because he had multiple comorbidities including diabetes. -Resident #3 had metabolic syndrome (a combination of health conditions including high blood pressure, high blood sugar, abnormal cholesterol levels and excess belly fat). -Her expectation was for Resident #3 to be weighed once a week and for the weight to be documented correctly so his weight could be monitored for a trend. -If there was a trend like weight gain the PCP would need to be notified by the facility. Interview with Resident #3 on 12/11/24 at 11:45am revealed: -Staff used to weigh him, but they did not weigh him anymore. -He did not know how often or when they used to weigh him. -He did not know the last time he was weighed or what his weight was. Interview with the medication aide (MA) on 12/12/24 at 2:45pm revealed: -She did not know how to work the scales on the weight chair. -The Director weighed the residents. -She did not see weights for Resident #3 on the eMAR. Interview with a second MA on 12/13/24 at 9:25am revealed: -The MAs weighed the residents twice monthly as part of their monthly vitals. -Some of the residents' weights were in the eMAR and some were written on a piece of paper she gave to the Director.	{D 276}		

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{D 276}	Continued From page 90 -None of the residents had were weighed weekly. Interview with the Director on 12/11/24 at 10:20am revealed: -Residents weights were only taken when there was a physician's order for them. -Some of the of the residents' weights were checked when their monthly vitals were taken. -The MAs weighed the residents and documented their weights. -The weights were documented and kept in a book; each resident had their own sheet to log their weights. Interview with the Director on 12/12/254 at 10:50am revealed: -She had to move the weight chair out of the storage room to weigh the residents. -She and the MAs weighed the residents on the 15th of every month. -The weights came up on the eMAR with the vitals for the residents with an order for them. -None of the residents had orders for weights more frequently than once a month. Interview with the Director on 12/12/24 at 3:15pm revealed: -She knew Resident #3 had an order for monthly weights. -Monthly weights were documented on a log and kept in a weight book. -She was not aware Resident #3 had an order for weekly weights written on 10/22/24. -She did not know the order also requested documenting the weekly weights on the eMAR. -She knew the PCP wrote an order for Resident #3 for diet sodas sometime in October 2024; she did not see the part about the weekly weights or documenting on the eMAR. -She did not know if the PCP sent the order to the	{D 276}		

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{D 276}	Continued From page 91 pharmacy. -She was responsible for placing the weekly weight order on the eMAR. -The weekly weights for Resident #3 were not being done because she did not know about them. -The MAs could weigh residents, because she had trained them on how to use the chair scale, but she usually did them to make sure they were done. -She was responsible for ensuring the weekly weights were done for Resident #3. -She would start the weekly weights today, 12/12/24. Interview with the Administrator on 12/16/24 at 4:20pm revealed: - He did not review physicians' orders; the Director was responsible for reviewing all physicians' orders for new orders or order changes. -It was her responsibility to follow through and make sure new orders or changes in orders were done. -He asked the Director if everything was being done and she would tell him if there were any issues. -He was not aware weekly weights were not done for Resident #3. -The Director should have ensured Resident #3's weekly weights were started that day or the next without delay. -The order should have been followed per the PCP and done by the staff. b. Review of Resident #3's current FL-2 dated 11/06/23 revealed there was an order for sliding scale insulin (SSI) four times daily based on finger stick blood sugar (FSBS) results.	{D 276}		

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{D 276}	Continued From page 92 Review of Resident #3's MAR for October 2024 revealed: -There was an entry to check and record FSBS prior to giving any/all insulin; fax results to PCP weekly scheduled at 7:30am, 11:30am, 4:30am and 8:00pm. -The entry was documented as completed four times daily but there were no results documented on the front or back of the MAR. -There was a second entry to check and record FSBS before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30am and 8:00pm. -The second entry was documented as completed four times daily but there were no results documented on the front or back of the MAR. Telephone interview with Resident #3's former PCP on 12/12/24 at 1:05pm revealed: -He had an order for SSI four times a day. -The SSI required a FSBS result in order to administer the correct amount of insulin. -The FSBS was part of the SSI order. -She expected the FSBS results to be documented so the PCP could review them for trends and to adjust the SSI if needed. Interview with Resident #3 on 12/11/24 at 11:45am revealed: -He had his "finger stuck all day long to check his sugar"; the MAs checked his FSBS with meals and at bedtime. -They used to forget to check it, but they did it all the time now. -He did not know how long ago it was when they would forget to do a FSBS check. -Sometimes he got a shot after the MA "stuck" his finger. -He did not know what his FSBS results were.	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	R 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 276}	Continued From page 93 Interview with a MA on 12/13/24 at 9:25am revealed: -Resident #3's FSBS checks were not documented on the MAR in October 2024 because there was nowhere to document them. -She did not write results on the MAR. -She would write his FSBS results on a piece of paper and place it in a book; the next day the paper was gone. -There was nowhere to document the amount of insulin she would administer per his SSI on the MAR either. -She told the Director in October 2024 there was no where to document the FSBS results and the SSI dose. -The Director asked the pharmacy for something to document on but they never sent anything. Interview with the Director on 12/10/24 at 4:20pm revealed: -The facility had paper MARs for October 2024 and switched to electronic medication administration records (eMAR) in November 2024. -The MAs were supposed to document Resident #3's FSBS results on the back of the MAR. -She was sure the FSBS checks were completed because Resident #3 had SSI, but the MA just did not document the results. -She told the MAs to write the FSBS results on the back of the MAR to show proof they were complete. -She did not know why the MAs did not know why they did not document the results. -She had not reviewed the October 2024 MARs; she thought the MAs were doing what they were supposed to be doing. Telephone interview with the Administrator on 12/17/24 at 2:42pm revealed:	{D 276}		

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{D 276}	Continued From page 94 -The MAs should have documented the FSBS readings on the back of the October 2024 paper MAR when it was obtained. -He expected the MAs to document the FSBS readings somewhere; if not on the MAR, they should have created a form. -The PCP would not know how to manage medications for the residents if there were no FSBS readings were not documented. -If the FSBS readings were not documented, then how could he determine the FSBS readings were obtained. 2. Review of Resident #1's current FL-2 dated 02/21/24 revealed diagnoses included cerebral vascular accident, coronary heart disease, and diabetes. a. Review of Resident #1's signed physician orders dated 02/21/24 revealed there was an order to check and record blood pressure (BP) twice daily. Review of Resident #1's October 2024 medication administration record (MAR) from 10/10/24 to 10/31/24 revealed: -There was an entry to check and record BP twice daily scheduled at 8:00am and 8:00pm. -There was documentation Resident #1's BP was checked twice daily from 10/10/24 to 10/28/24 and on 10/30/24; and on 10/29/24 and 10/31/24 at 8:00am; but there were no BP readings documented. -There was no documentation Resident #1's BP was checked on 10/29/24 and 10/31/24 at 8:00pm; the MAR was blank. Interview with a medication aide (MA) on 12/12/24 at 2:41pm revealed: -Resident #1's BP was taken as ordered.	{D 276}		

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{D 276}	Continued From page 95 -She signed her initials on the MAR when she checked Resident #1's BP. -There was nowhere to document Resident #1's BP readings. -She had not spoken to the Director about where to document Resident #1's BP readings. Interview with another MA on 12/13/24 at 8:06am revealed: -Resident #1's BP checks were not documented on the MAR in October 2024 because there was nowhere to document them. -She did not write results on the MAR. -She would write the blood sugar readings on a piece of paper and throw the paper in the trash; it was not a legal form. -She told the Director in October 2024 there was nowhere to document the BP readings. -The Director notified the pharmacy and asked for a form to record the BP readings on, but no form was received. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 12/11/24 at 2:36pm revealed: -The pharmacy did not enter a BP check onto the MAR for Resident #1; the data would not transfer to the MAR screen. -It was the facility's responsibility to enter the BP check onto the MAR. -The pharmacy only entered medications onto the MAR. Interview with the Director on 12/16/24 at 5:03pm revealed: -The MAs were supposed to document Resident #1's BP readings on the back of the MAR. -The MAs had been instructed to document Resident #1's BP on the back of the paper MARs until the computers were up and running.	{D 276}		

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{D 276}	Continued From page 96 -She was sure the BP readings were done, but the MA just did not document the results. -She told the MAs to write the BP readings on the back of the MAR to show proof they were complete. -She did not know why the MAs did not document the results. -She had not reviewed the October 2024 MARs; she thought the MAs were doing what they were supposed to be doing. -The PCP would not know how to adjust medications if there were no BP readings to review. -She could add a place for the BP readings to be documented on the eMAR. -She did not know she needed to add a place for the BPs to be documented on the front of the paper MAR. Telephone interview with the Administrator on 12/17/24 at 2:42pm revealed: -The MAs should have documented the BP readings on the back of the October 2024 paper MAR when it was obtained. -He expected the MAs to document the BP readings somewhere; if not on the MAR, they should have created a form. -The PCP would not know how to manage medications for the residents if there were no BP readings documented. -If the BP readings were not documented, how could it be determined the BP readings were obtained. Attempted telephone interviews with Resident #1's primary care provider (PCP) on 12/13/24 at 10:09am and on 12/16/24 at 9:00am were unsuccessful. Based on observations, interviews, and record	{D 276}		

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{D 276}	Continued From page 97 reviews it was determined Resident #1 was not interviewable. b. Review of Resident #1's signed physician orders dated 02/21/24 revealed there was an order to check and record fingerstick blood sugars (FSBS) before meals and at bedtime. Review of Resident #1's October 2024 MAR from 10/10/24 to 10/31/24 revealed: -There was an entry to check and record FSBS readings before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -There was documentation Resident #1's FSBS were checked four times daily before meals and at bedtime from 10/10/24 to 10/30/24; and on 10/31/24 at 7:30am, 11:30am, and 4:30pm, but there was no FSBS readings documented. -There was no documentation the FSBS was checked on 10/31/24 at 8:00pm; the MAR was blank. Interview with a MA on 12/13/24 at 8:06am revealed: -Resident #1's FSBS checks were not documented on the MAR in October 2024 because there was nowhere to document them. -She did not write FSBS readings results on the MAR. -She would write the FSBS readings on a piece of paper and threw the paper in the trash; it was not a legal form. -She told the Director in October 2024 there was nowhere to document the FSBS readings. -The Director notified the pharmacy and asked for a form to record the FSBS readings on, but no form was received. Interview with the Director on 12/16/24 at 5:03pm revealed:	{D 276}		

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{D 276}	Continued From page 98 -The MAs were supposed to document Resident #1's FSBS readings on the back of the MAR. The MAs had been instructed to document Resident #1's FSBS readings on the back of the MARs until the computers were up and running. -She was sure the FSBS readings were done, but the MA just did not document the readings. -She told the MAs to write the FSBS readings on the back of the MAR to show proof they were complete. -She did not know why the MAs did not document the results. -She had not reviewed the October 2024 MARs; she thought the MAs were doing what they were supposed to be doing. -The PCP would not know how to adjust medications if there were no FSBS readings to review. -She could add a place for the FSBS readings to be documented on the eMAR. -She did not know she needed to add a place for the FSBSs to be documented on the front of the paper MAR. Telephone interview with the Administrator on 12/17/24 at 2:42pm revealed: -The MAs should have documented the FSBS readings on the back of the October 2024 paper MAR when it was obtained. -He expected the MAs to document the FSBS readings somewhere; if not on the MAR, they should have created a form. -The PCP would not know how to manage medications for the residents if there were no FSBS readings to review. -If the FSBS readings were not documented, how could it be determined the FSBS readings were obtained. Attempted telephone interviews with Resident	{D 276}		

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{D 276}	Continued From page 99 #1's PCP on 12/13/24 at 10:09am and on 12/16/24 at 9:00am were unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. 3. Review of Resident #5's current FL-2 dated 09/21/24 revealed: -Diagnosis included diabetes mellitus. -There was an order to check and record fingerstick blood sugar (FSBS) readings before giving any and all insulin (insulin was scheduled four times daily). Review of Resident #5's October 2024 medication administration record (MAR) from 10/10/24 to 10/31/24 revealed: -There was an entry to check and record FSBS readings before meals and at bedtime. -There was documentation Resident #5's FSBS was checked four times daily from 10/01/24 to 10/30/24 but there were no FSBS readings documented. -There was no documentation Resident #5's FSBS was checked on 10/31/24 at 7:30am, 11:30am. 4:30pm and 7:30pm; the MAR was blank. Interview with Resident #5 on 12/12/24 at 11:25am revealed: -The medication aides (MA) checked her FSBS several times a day; she was not sure how often. -She did not know what her FSBS readings were or if the MAs wrote them down anywhere. Attempted telephone interviews with Resident #5's primary care provider (PCP) on 12/13/24 at 10:09am and on 12/16/24 at 9:00am were unsuccessful.	{D 276}		

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{D 276}	Continued From page 100 4. Review of Resident #6's current FL-2 dated 05/17/24 revealed diagnosis included diabetes mellitus. Review of Resident #6's signed physician orders dated 05/17/24 revealed there was an order for fingerstick blood sugar (FSBS) checks before meals and at bedtime. Review of Resident #6's October 2024 medication administration record (MAR) from 10/10/24 to 10/31/24 revealed: -There was an entry to check FSBS readings before meals and at bedtime scheduled at 7:30am, 11:30am. 4:30pm and 7:30pm. -There was documentation Resident #6's FSBS was checked four times daily from 10/01/24 to 10/30/24 but there were no FSBS readings documented. -There was no documentation Resident #6's FSBS was checked on 10/31/24 at 7:30am, 11:30am. 4:30pm and 7:30pm; the MAR was blank. Interview with Resident #6 on 12/12/24 at 11:35am revealed: -The medication aide (MA) checked his FSBS four times a day. -Sometimes he received insulin based on what his FSBS readings were. Interview with a MA on 12/12/24 at 2:41pm revealed: -She did not realize there was nowhere on Resident #6's MAR to document his FSBS readings. -Resident #6's FSBS readings should be documented on the MAR. -She thought the FSBS readings should be	{D 276}		

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{D 276}	Continued From page 101 documented on the back of the MAR. -She forgot to document the FSBS readings on the back of the MAR. Attempted telephone interviews with Resident #6's primary care provider (PCP) on 12/13/24 at 10:09am and on 12/16/24 at 9:00am were unsuccessful. 5. Review of Resident #7's current FL-2 dated 07/25/24 revealed diagnoses included diabetes mellitus type 2. Review of Resident #7's signed physician orders dated 07/25/24 revealed there was an order for fingerstick blood sugar (FSBS)checks daily. Review of Resident #7's October 2024 medication administration record (MAR) from 10/10/24 to 10/31/24 revealed: -There was an entry for FSBS checks every morning with a scheduled time of 7:30am. -There was documentation FSBS checks were done each morning from 10/10/24 to 10/31/24 but there were no FSBS readings documented. Attempted telephone interviews with Resident #7's primary care provider (PCP) on 12/13/24 at 10:09am and on 12/16/24 at 9:00am were unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable. _____ Interview with a MA on 12/13/24 at 8:06am revealed: -Resident's FSBS checks were not documented on the October 2024 MAR because there was nowhere to document them.	{D 276}		

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{D 276}	Continued From page 102 -She did not write FSBS readings results on the MAR. -She would write the FSBS readings on a piece of paper and threw the paper in the trash; it was not a legal form. -She told the Director in October 2024 there was nowhere to document the FSBS readings. -The Director notified the pharmacy and asked for a form to record the FSBS readings on, but no form was received. Interview with the Director on 12/16/24 at 5:03pm revealed: -The MAs were supposed to document on the residents' FSBS readings on the back of the MAR. The MAs had been instructed to document to document FSBS readings on the back of the MARs until the computers were up and running. -She was sure the FSBS readings were done, but the MA just did not document the readings. -She told the MAs to write the FSBS readings on the back of the MAR to show proof they were complete. -She did not know why the MAs did not document the results. -She had not reviewed the October 2024 MARs; she thought the MAs were doing what they were supposed to be doing. -The PCP would not know how to adjust medications if there were no FSBS readings to review. She could add a place for the FSBS readings to be documented on the eMAR. Telephone interview with the Administrator on 12/17/24 at 2:42pm revealed: -The MAs should have documented the FSBS readings on the back of the October 2024 paper MAR when it was obtained.	{D 276}		

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{D 276}	Continued From page 103 -He expected the MAs to document the FSBS readings somewhere; if not on the MAR, they should have created a form. -The PCP would not know how to manage medications for the residents if there were no FSBS readings to review. -If the FSBS readings were not documented, then how could it be determined the FSBS readings were obtained. _____ The facility failed to implement orders for 4 residents who had FSBS checks before meals and at bedtime (#1, #3, #5, and #7) with a sliding scale insulin order to be administered based on the FSBS reading; one resident, who had a history of hypertension and stroke with an order to obtain BP readings twice daily that were not obtained (#1); and a resident who had a 3 percent weight loss from November 2024 to 12/12/24, and weekly weights were not obtained. This failure of the facility was detrimental to the health, safety, and welfare or the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/16/24. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2024.	{D 276}		
D 277	10A NCAC 13F .0902 (d) Health Care 10A NCAC 13F .0902 Health Care (d) The following shall apply to the resident's physician or physician service: (1) The resident or the resident's responsible	D 277		

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D 277	Continued From page 104	D 277		

person shall be allowed to choose a physician or physician service to attend the resident.
(2) When the resident cannot remain under the care of the chosen physician or physician service, the facility shall assure that arrangements are made with the resident or responsible person for choosing and securing another physician or physician service within 45 days or prior to the signing of the care plan as required in Rule .0802 of this Subchapter.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews and record reviews, the facility failed to coordinate services with a new primary care provider (PCP) in a timely manner for 21 of 22 residents after the previous PCP had provided a 30-day notice to the facility of the termination of physician services.

The findings are:

Review of the notification letter to terminate physician services from the facility's former primary care provider (PCP) dated 10/31/24 revealed:
-The physician services would be discontinued on 11/30/24.
-Services during the 30-day notice period would be through telehealth unless the provider determined an in-person visit was required.
-Providers would be available to the facility to respond to any urgent care needs 30 days from this notice.

Telephone interviews with the Director of Clinical Operations for the facility's former PCP's office on

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D 277	Continued From page 105 12/12/24 at 2:20pm and 3:27pm revealed: -The facility staff were notified in October 2024 that their services were being stopped. -The facility was given a 30-day notice in writing. -If there were any medications that needed to be ordered before their services stopped, they would work with the facility to resolve the issue, but the facility was given ample notice. -In mid-November 2024, they received a transmission that prescriptions were needed and those were addressed. -On Thanksgiving Day, thirty-four prescriptions were sent in. -He wanted the residents taken care of but technically the residents were no longer their patients as of 12/01/24. -They were going over and above and would do refills for one month for medications the residents were out of "right now." Review of the Director's hand-written document regarding provider contacts revealed: On 11/04/24, she called a local rehabilitation center to inquire who provided their physician services; she left a message, but she did not receive a return telephone call. -On 11/07/24, she called a local assisted living facility (ALF) to inquire who provided their physician services; she left a message, but she did not receive a return telephone call. -On 11/12/24, she called a second local ALF to inquire who provided their physician services; she left a message, but she did not receive a return telephone call. -On 11/21/24, she called a local provider to inquire if there was a physician available to provide services to the residents; she left a message. -On 11/26/24, she received a return phone call from the local provider that the physician was	D 277		

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unable to assist.
-On 11/29/24, she called a second local provider and was told they were accepting residents and to complete the paperwork needed for the residents and bring the paperwork to their office.

Review of an email sent by the Director to a third provider on 11/20/24 at 10:10am revealed a request to see if the provider was interested in being the facility's provider.

Review of the response email sent to the Director from the third provider on 11/20/24 at 10:13am revealed:
-There were providers available, and the response included the monthly cost and a form to complete regarding the facility's information.
-There was no response from the Director to this email to review.

Interview with the Director on 12/10/24 at 10:23am revealed:
-The facility was no longer serviced by their former PCP.
-The facility received a letter from their former PCP's provider group in October 2024 that the agency would no longer provide physician services.
-She called the former PCP and was told the facility was located too far from their office for them to continue services.
-The second local provider was contacted a couple of weeks ago, maybe the week before the Thanksgiving holiday, to see if they would service the residents.
-She spoke with the receptionist and was informed the second local provider was accepting new clients.
-The receptionist told her to complete the initial paperwork found online and bring the paperwork

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to the office.
-She had all the residents' orders printed and ready to take to the their office as of 12/10/24; she planned to take the printed orders to their office tomorrow morning, 12/11/24.

Observation of the Director's office on 12/10/24 at 10:00am revealed the resident's uncompleted paperwork for the second local provider contacted on 11/29/24, was on the Director's desk.

Telephone interview with the Registered Nurse (RN) at the second local provider's office on 12/10/24 at 10:28am revealed:
-The Director at the facility called their office and spoke to the receptionist.
-She knew the Director was instructed to complete a new patient packet for the residents she was inquiring about.
-The Director called her a few weeks ago and stated they were having issues acquiring a new PCP for the facility.
-The Director stated the facility would like to work with a local provider so the response time for resident concerns would be quicker.
-The second local provider had not accepted any residents from the facility; the Director had not brought any new patient packets to the their office.
-Their office would also need a signed release for medical forms and a signed release to provide services to each resident.

Telephone interview with the receptionist at the second local provider's office on 12/10/24 at 10:37am revealed:
-She received the initial telephone call from the Director of the facility a few weeks ago, (she did not recall the exact date), stating the need for a

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new PCP for some residents at the facility.
-She informed the Director that the residents would need a new patient packet completed, including insurance information and medical records.
-She had not heard from the Director since the initial telephone call.
-She had not received any new patient packets or information for new residents.

Interview with the Director on 12/11/24 at 3:39pm revealed:
-The residents' information was taken to the second local provider's office this morning.
-She received a phone call from the receptionist from the second local provider's office stating the physician would not be visiting the facility to see residents; he was not a "facility provider", but the resident could be brought to their office.
-She spoke to the RN at the second local provider's office who informed the Director of the process for new patients.
-The process was to have a signed release for medication records completed.
-Once the medical records were reviewed then an appointment could be made.

Telephone interview with the RN at the second local provider's office on 12/11/24 at 4:27pm revealed:
-The Director was instructed to have the release for medical information signed by the appropriate person.
-Once the medical information was received and reviewed, then an appointment would need to be made by the legal guardian.
-It could take 1 to 2 weeks to get an appointment once the medical information had been received.
-The legal guardian would have to bring the resident to the initial appointment.

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D 277	Continued From page 109 Interview with the Administrator on 12/11/24 at 5:25pm revealed: -The residents not having a current PCP happened suddenly and quickly. -The facility was notified that the former PCP was retiring and was given a 30-day notice. -"We began the process to find another provider." -The Director was working on coordinating a PCP for the residents but "he probably threw out some names." -He had talked to one provider and the provider said it would be a couple of weeks so the Director had contacted the second local provider, and he thought that one would be faster. -He found out today, 12/11/24, that the information they had been told was not sufficient and if the residents were going to be seen by the second local provider, each resident's power of attorney (POA) or guardian would need to call and make an appointment and take the resident to the first appointment. -He was not sure when the Director reached out to this second local provider but thought it was the end of November 2024, the first of December 2024. -If he had known before today, the POAs/guardians would have already been notified to have appointments set up. -To the best of his knowledge the POAs/guardians were notified by the Director that the facility's PCP was going to change. -If a resident did not have a POA/guardian, the resident signed the initial information needed by the second local provider's office. -He thought only 5 of 22 residents had POAs/guardians. -He was not aware there were residents without medication refills until the Director told him a "little while ago," today 12/11/24.	D 277		

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D 277	Continued From page 110 -He thought everything had been taken care of by the former PCP before 11/30/24. -His primary concern was first and foremost a PCP needed to be secured for the residents. -He did not know how long it would take to get the residents in to see the second local provider. -He did not know if the residents were given an option to find their own PCP. -If a resident had a problem, the resident would have to be sent to the ED since there was no PCP to contact at that moment. -He had not reached back out to the former PCP because he thought the problem was solved when the second local provider was identified. -The only thing he could do was call the second local provider's office and let them know the residents were in a crisis to ensure the residents received the medication they needed. Interview with the Director on 12/11/24 at 6:01pm revealed: -She had left voicemails for two guardians today, 12/11/24, who were the guardians for 4 residents. -She had not contacted the guardian for the other resident with a guardian. Interview with a resident on 12/11/24 at 6:15pm revealed: -He saw a local provider before being admitted to the facility. -When he was admitted to the facility, he started seeing the facility's PCP. -He thought he had to see the facility's PCP. -The Director told him the facility was getting a new PCP. -The Director told him to complete paperwork for a new PCP; he completed the paperwork the first week of December 2024. -He was not told why the facility was getting a new PCP.	D 277		

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D 277	Continued From page 111 -The previous PCP used to come to the facility every Tuesday. -There had not been a PCP in the facility for several weeks. -He could not remember the last time the PCP was in the facility. -He was not asked if he wanted to see a certain PCP. -He would like to return to the local provider he saw before being admitted to the facility. Interview with a second resident on 12/11/24 at 6:15pm revealed: -The Director told him the facility was getting a new PCP. -The Director told him to complete paperwork for a new PCP; he completed the paperwork the first week of December 2024. -There had not been a PCP in the facility for several weeks. -He could not remember the last time the PCP was in the facility. Interview with a third resident on 12/11/24 at 6:20pm revealed he was given papers to sign the first of last week for the new PCP. Interview with a fourth resident on 12/11/24 at 6:20pm revealed: -He was told there was going to be a new PCP 3 to 4 days ago when the Director asked him to sign papers. -He did not know what the papers were. -He was his own responsible party. -He "guessed" he was okay with a new PCP. Interview with a fifth resident on 12/11/24 at 6:21pm revealed: -The Director told him about a week ago that they were getting a new PCP.	D 277		

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D 277	Continued From page 112 -He signed paperwork about 3 to 4 days ago. -He was not given a choice to pick a new PCP. Interview with a sixth resident on 12/11/24 at 6:24pm revealed: -The Director had him sign a piece of paper on 12/09/24 or 12/10/24 for a new PCP. -The previous PCP had retired, and the facility was getting a new PCP. -The first time he heard that a new PCP was coming to the facility was on the day he signed the paperwork for a new PCP. Interview with a seventh resident on 12/11/24 at 6:25pm revealed: -No one told him he needed a new PCP. -He had needed to see the previous PCP for about a month. -His left ear was clogged, and he could not hear out of it. -He did not tell the staff because he was waiting to tell the previous PCPwhen he saw her. -He thought he was due to see the previous PCP this week. -He did not recall signing any papers and he did not recall anyone talking to him about changing PCPs. -If he had a new PCP no one told him, and he would have liked to have been given a chance to pick his own. -He was responsible for himself. Interview with an eighth resident on 12/11/24 at 6:26pm revealed: -This week, 12/09/24, he was told the facility was changing PCPs. -He was given papers to sign for the new PCP. Telephone interview with a resident's guardian on 12/12/24 at 9:49am revealed the Director texted	D 277		

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D 277	Continued From page 113 her a "couple of days ago" to let her know the facility was changing PCPs. Telephone interview with another resident's guardian on 12/16/24 at 10:22am revealed: -She was notified this past Friday, 12/13/24, about the facility changing PCPs. -She knew she was going to have to complete the paperwork for initial consent and accompany the residents to their first appointment. Interview with a representative from the second local provider's office on 12/12/24 at 3:42pm revealed: -None of the residents had appointments with their physician. -When they were first asked if they were taking new patients, they stated they were, but then found out there were going to be over 20 new patients. -The only way their practice would take residents from the facility would be the residents to be alert and oriented x 3, responsible for themselves, and sign for themselves. -Their process was to obtain medical records for the residents and then the physician would decide if he could handle the needs of the residents. -If the physician agreed to be the PCP for the residents, an appointment would then be made for that resident. -If a resident could not sign for themselves their family member would need to come into the office to complete the necessary paperwork, and the physician would then do the same process to decide if he was going to be the PCP for that resident. -She thought it might be in the best interest of the facility to find a different PCP that would go into the facility because it could be months before the residents could all be set up with their office.	D 277		

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D 277	Continued From page 114 Interview with the Director on 12/16/24 at 3:11pm revealed: -She had not heard from the fourth provider she had contacted on 12/13/24. -She reached out to the facility's mental health provider (MHP) and was told their agency provided PCPs for ALFs. -She talked to a representative with the MHP's primary care group today, 12/16/24, and the Administrator had completed an online registration form. Interview with the Administrator on 12/16/24 at 4:46pm revealed: -He had received a call from the fourth provider's office, the one contacted by the Director on 12/13/24, and was informed they would not be able to provide a PCP for the facility at this time. -He had completed the online registration for the fifth provider, which was the primary care group from their current MHP. Telephone interview with the Administrator on 12/17/24 at 2:42pm revealed: -He had not heard back from the fifth provider but he completed the online registration form on 12/16/24. -He told the Director to call a sixth provider today to see if the provider had any recommendations. -The Director told him she had already tried this local provider, and the provider did not have voicemail set up. 1. Review of the facility's contracted pharmacy cycle refills pending prescriber renewals generated on 11/27/24 revealed: -There were 16 residents who needed refills on medications as of 11/27/24. -One residents anti-seizure medication was filled	D 277		

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on 11/01/24 for a one-month supply; there were no refills on the medication.
-A second resident had two blood pressure medications last filled on 11/01/24 for a one-month supply; there were no refills on the medication.
-The same resident had a medication used to treat high cholesterol that was last filled on 11/01/24 for a one-month supply; there were no refills on the medication.
-A third resident had two blood pressure (BP) medications last filled on 09/09/24 for a one-month supply; there were no refills on the medication.
-Thirteen residents needed refills on supplements including a medication used to control acid reflux, a medication used to aid in sleeping, a stool softener, and supplements for potassium, vitamin D3, omega-3 fish oil, calcium, folic acid, B-vitamins, and a multivitamin.

Observation of the second resident's BP on 12/10/24 at 3:55pm revealed a BP of 146/100.

Review of the second resident's BP reading dated 12/17/24 revealed a BP of 151/101.

Review of a third resident's BP readings from 12/01/21 to 12/13/24 revealed BP's of 166/112 on 12/02/24, 169/114 on 12/09/24, 164/104 on 12/10/24, and 178/74 on 12/12/24.

Interview with a medication aide (MA) on 12/12/24 at 10:56am revealed:
-She did not call the primary care provider (PCP0 about residents.
-She told the Director, and the Director would call the PCP.

Interview with the Director on 12/12/24 at 3:38pm

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D 277	Continued From page 116 revealed: -The MAs could call the former PCP about a resident. -She did not know if they were aware they could contact the former PCP; she usually called the former PCP. -She did not know what they were going to do now since they did not have a PCP. -She "guessed" they would have to send the residents to the emergency department (ED) if the resident were sick. Interview with the Director on 12/11/24 at 3:58pm revealed: -She received notifications from the pharmacy in early November 2024 of what prescriptions needed refills. -She used the telemedicine system with the former contracted PCP to get refills; the telemedicine system was linked to the former contracted PCP's office. -She could not provide any updates of medication refills because she could no longer get into the telemedicine system of the former contracted PCP as of 11/30/24, the day services were terminated. -Some of the medications had been delivered. -She was still waiting for some of the medications to be refilled. -She did not know what medications had been refilled and what medications were still pending. Interview with the Director on 12/16/24 at 3:11pm revealed: -She knew something was going on with the medication because so many did not come in with the November cycle filled medications. -She noticed three residents were missing multiple medications. -She had the pharmacy renewal form which she	D 277		

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sent to the former contracted PCP's office.
-After three attempts to get the medication refilled, she called a [named] person at the former PCP's office.
-The former PCP responded back at that point and there was a problem with the pharmacy accepting the form the former PCP signed, and it was kicked back.
-At that point, she was told by the pharmacy that the former PCP had to send individual prescriptions for each resident.
-She went into each resident's record in the telemedicine system and put in the needed information for each prescription.
-Some of the medications were delivered and some were not.
-The MAs would write down what medications were still needed.
-The Administrator was not aware residents were out of their medications until after the survey team entered the facility.
-The Administrator asked her why she had not told him.
-She had not told the Administrator because she thought she had worked it out.

Interview with the Administrator on 12/11/24 at 5:25pm revealed:
-He was not aware there were residents without medication refills until the Director told him a "little while ago," today 12/11/24.
-He thought everything had been taken care of by the former PCP before 11/30/24.
-His primary concern was first and foremost a PCP needed to be secured for the residents.
-If a resident had a problem, the resident would have to be sent to the ED since there was no PCP to contact at that moment.
-He had not reached back out to the former PCP because he thought the problem was solved

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when the second local provider was identified.
-The only thing he could do was call the second local provider's office and let them know the residents were in a crisis to ensure the residents received the medication they needed.

Based on observations, record reviews, and interviews, sixteen residents were without medications after their last refills, dated 11/01/24, which resulted in two residents with elevated BPs who had not received their BP medication because they did not have refills.

2. Review of a resident's monthly weight log from January 2024 to November 2024 revealed:
-The resident had monthly weights documented between 108 pounds to 110 pounds from January 2024 to November 2024.
-The resident weighed 97.5 pounds on 12/13/24.

Interview with the Director on 12/16/24 at 5:03pm revealed:
-They did not have a current primary care provider to notify the resident's weight loss.
-The resident would be taken to urgent care or the emergency department (ED) if she needed to be seen due to weight loss.

Telephone interview with the Administrator on 12/17/24 at 2:53pm revealed:
-The PCP should be notified of the resident's weight loss, but there was currently no PCP to notify.
-The resident would have to go to the ED related to her weight loss.

Based on the resident's documented weight on the weight log, the resident had an 11 percent weight loss from November 2024 to 12/13/24.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 277	Continued From page 119 3. Review of four residents' records revealed FL-2s that were last updated in November 2023. Interview with the Director on 12/10/24 at 4:20pm revealed: -There were multiple residents without a current FL-2 because the facility did not have a current primary care provider (PCP) to sign off on them. -She did not know how many residents had expired FL-2s. -A new PCP, once obtained, would have to sign the expired FL-2s. -She knew the residents were required to have an annual exam and to have the FL-2 completed at that exam. _____ The facility failed to ensure each resident had a primary care provider (PCP) to provide medical care including refills for medications, updated FL-2s, and notification of residents with elevated BPs and other medical needs, when the former PCP gave the facility a 30-day notice that their services would end on 11/30/24. This failure resulted in two residents, who missed blood pressure medications having elevated BPs without physican notification, and multiple residents going several days without medications because there were no refills for their medications. This failure resulted in a substantial risk of physical harm to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/24. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 16, 2025.	D 277		

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D 283	Continued From page 120	D 283		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure all food items stored and prepared by the facility were served under sanitary conditions related to a dirty food storage and preparation area windowsills, rodent droppings on shelves and floors in the dry storage area; and dirty floors in the kitchen. The findings are: Observation of the kitchen on 12/10/24 at 8:55am revealed: -There was a build-up of a sticky substance on the handles of the two reach-in coolers that could be scrapped off with a finger nail.	D 283		

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D 283	Continued From page 121 -There was grayish-black residue on the inside of the second reach-in cooler. -There was water dripping from the fans inside the first cooler and collecting in a full pan of cloudy pinkish water on the top shelf. -There was an accumulation of brownish-yellow water on the floor of the first cooler. -There was a thick brown build-upon the outside handle of the reach-in freezer. -There was a black film on the folds to the inside of the freezer. -There were crumbs, dried spills and debris on the inside ledge of the freezer door. -There was a large frozen reddish-brown puddle on the floor of the freezer. -There was a drawer in the metal serving table where utensils were stored that had a dried brown liquid in the drawer and on the utensils. -There was a dried brown liquid in the drawer and on the utensils. -There were rodent droppings in the drawer with the utensils. -There was a thick black layer of baked on grease and food on the grates on the stove. -There was food, grease and debris around the six burners on the stove. -There was a thick sticky yellow build-up around and on the control knobs of the front of the stove. -There were sticky yellow drips of grease on the front of the oven door. -There was a large accumulation of burnt debris inside the oven and a large hard black area on the bottom of the oven. -There was a thick layer of yellow grease, a thick build-up of black dust and clumps of black dust hanging on the inside walls of the hood above the stove. -There were dead flies, cobwebs, a black debris and dust on the windowsills and widow air conditioner in the dry storage area.	D 283		

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D 283	Continued From page 122 -There were rodent droppings on the floors and shelving in the dry storage area. -There was debris, paper items, rodent droppings and food on the floor behind and under the stove, equipment and shelving in the kitchen. -There was a large mat with quarter size circular openings in the design on the floor near the dish machine. -There was dirt and debris accumulated in the open circles. -There was a build-up of dirt and debris under the mat and dirt and debris stuck to the floor from the openings in the mat. Review of the local health department (LHD) food establishment inspection report for the kitchen dated 09/20/24 revealed: -The facility received a score of 95. -There was documentation of observations of rodent droppings found on shelves in the [dry] storage room and inside several storage containers, the need to clean/remove droppings and the need to notify the pest control company. -The cooking surface of the stovetop had a large accumulation of grease/food debris build-up and needed cleaning. -The hood vents had accumulation of grease build-up and needed cleaning. Review of the kitchen cleaning schedule revealed: -The cleaning schedule hanging on the bulletin board in the kitchen. -The cook removed multiple cleaning schedules from the bulletin board. -The cleaning schedule dated October 2024 had initials for some of the cleaning tasks but was not complete. -There was nothing documented on the cleaning schedules for November 2024 and December	D 283		

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D 283	Continued From page 123 2024. -The hood over the stove, grates on the stove, windowsills, freezer and cooler shelves, and the shelves in the dry storage were to be cleaned weekly; they were documented as cleaned on 10/22/24. -The storage drawer in the table, was to be wiped out daily and was documented as cleaned on 10/22/24. -The floors were to be mopped daily and was last documented as cleaned on 10/22/24. -The floors were to be swept after each meal and were documented as complete once daily in October 2024. Interview with the cook on 12/10/24 at 8:55am revealed: -She pulled the floor mat up every two weeks and cleaned under it; it was due to be cleaned. -The drawer in the prep table was supposed to be cleaned every other day; it had been about a month since it was last cleaned. -The walls inside the hood were cleaned in September 2024 by the Supervisor. -The stove top was taken apart and deep cleaned every two weeks and it was due to be deep cleaned again; she cleaned it about two weeks ago. -Spills and splatters on the stove were cleaned daily. Interview with the cook on 12/11/24 at 11:21am revealed: -She had not had a chance to document on the cleaning schedule since October 2024. -She tried to complete everything on the schedule, but she did not always look at the schedule when she cleaned; she had been at the facility long enough she knew what to clean each day.	D 283		

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D 283	Continued From page 124 Interview with the cook on 12/13/24 at 2:33pm revealed: -The hood screens had been cleaned but the rest of the hood had not finished due to lack of time. -Saturdays were for deep cleaning and she would finish the hood then. -The drawer was cleaned out weekly and was last done two months ago due to lack of time. -The windowsills were cleaned every Monday, but the one in the storeroom had been missed because she forgot it was there. -The windowsill in the storeroom was last cleaned before she started working at the facility. -The reach-in coolers were last cleaned about a month ago; they were supposed to be cleaned inside and outside every day. -The freezer was deep cleaned about two weeks ago; it was supposed to be done every two weeks. -The outside door to the freezer should be cleaned every day. -The shelves in the dry storage were cleaned about a month ago; the mouse droppings were new. -She had seen mice running in the kitchen and seen new droppings. -The shelves in the dry storage were scheduled to be cleaned as needed. -The floors were scheduled to be swept and mopped once daily. -The floors were scheduled to be deep cleaned, including under and behind the equipment, once weekly. -She did not know the knobs to the stove could come off, so she had never cleaned behind them. -The oven had not been cleaned; she was scared to clean it because they used it all day and did not want it to catch fire.	D 283		

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D 283	Continued From page 125 Interview with the Supervisor on 12/13/24 at 8:38am revealed: -The cooks did the day to day and deep cleaning in the kitchen. -She or the Director checked to see if the cleaning was being done; she helped serve meals every day. -The last time she checked was about three weeks ago; the cook was cleaning the walls, baseboards and sink. -She had not checked on the cleaning log in about three weeks; the cook had told her she had not filled it in because she had not had a chance. -She did not know the windowsill was dirty and she did not know how often it was supposed to be cleaned. -The reach-in coolers were cleaned everyday including the outside doors and the handles. -The inside of the reach-in coolers were cleaned every other day. -She did not check the reach-in cooler everyday to see if they were clean. -The reach-in freezer was cleaned the first of last week. -She did not get all of the ice out of the bottom of the freezer when she cleaned it. -The door handles and gaskets were cleaned daily. -She did not check the freezer daily and did not know the last time she had checked it. -She had not noticed the mouse droppings anywhere; they kept the food in plastic bins to keep the mice out. -The floors in the kitchen and store room were supposed to be swept and mopped including under and behind equipment every day. -The floor mat was supposed to be lifted up and taken out and sprayed with the hose a couple times a week. -The last time she thought the floor mat had been	D 283		

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D 283	Continued From page 126	D 283		

cleaned was a couple of weeks to a month ago.
-The floor mat was heavy so they swept under it when they could, but they always swept under it when they took it outside to clean.
-She did not know the drawer in the table was not clean; it was supposed to be cleaned as it got dirty.
-She had not seen the mouse droppings in the drawer.
-The stove top was supposed to be cleaned daily or as soon as there were spills.
-The grates on the stovetop were supposed to be deep cleaned every two weeks and were on the cleaning list.
-The knobs on the front of the stove and the oven were part of the daily cleaning but they were not cleaned behind.
-She did not know how often the oven was cleaned and she was not sure if it was on the cleaning schedule.
-She had cleaned the ventilation screens in the hood, but had not gotten to the walls of the hood.
-She was waiting on help from maintenance to clean the hood.
-She expected the kitchen staff to do a better job at keeping the kitchen clean.

Interview with the Director on 12/16/24 at 12:20pm revealed:
-She inspected the kitchen periodically; she went into the kitchen about twice a week.
-If she saw something that needed cleaning, she would let the cook know.
-She looked for cleanliness, spills and at the equipment in general.
-She did not do a deep inspection.
-The coolers, freezers, floors, under the floor mat and stove were scheduled to be cleaned every day.
-The drawer in the table was supposed to be

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D 283	Continued From page 127 cleaned as needed; it was clean when she saw it two weeks ago. -The oven, stove grates, floor mat, shelves and hood were on the schedule for deep cleaning and as needed. -She did not know the frequency. -She looked for mouse droppings but had not seen them lately; the pest control company had been treating the entire facility for mice. -She thought the cooks were completing the cleaning schedule because she thought she saw signatures on them. -She expected the kitchen staff to follow the cleaning schedule and keep the kitchen clean. Interview with the Administrator on 12/16/24 at 3:40pm revealed: -The cooks and the Director were responsible for the sanitation in the kitchen by following the cleaning log. -The Director was responsible for checking the cleaning logs and inspecting the kitchen. -He did not look at the cleaning logs. -He looked at the kitchen to see if it was clean at least once a week. -He looked at the kitchen and the floors; he looked at the overall condition of the kitchen staff. -He would tell the kitchen staff and the Director if he saw something that needed attention. -The last time he looked at the kitchen was week before last; the floors needed to be cleaned so he told the kitchen. -He expected the Director to make sure the sanitation in the kitchen was maintained.	D 283		
{D 299}	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service	{D 299}		

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{D 299}	Continued From page 128 (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that 8 ounces of milk or other equivalent of dairy servings were served three times daily to the residents. The findings are: Review of the facilty's current census on 12/10/24 revealed there were 22 residents residing in the facility. Based on the recommended servings of 8 ounce of milk three times a day the facilty would have used four gallons of milk per day to serve 22 residents. Review of the weekly menu for 12/10/24, 12/11/24 and 12/13/24 revealed: -Milk was to be served at breakfast and dinner everyday. -There was no dairy items on the menu for lunch on 12/10/24 and 12/11/24.	{D 299}		

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{D 299}	Continued From page 129 Observation of the reach-in cooler and freezer in the kitchen on 12/10/24 at 8:58am revealed: -There was a three quarters full gallon of milk in the cooler; there was no other milk. -There was a block of American cheese that was opened, but there were no other dairy items available to serve to the residents. Observation of the reach-in cooler in the kitchen on 12/11/24 at 12:17pm revealed: -There was a half a gallon of milk available for serving to the residents; there was no other milk available. -There was a block of American cheese that was opened, but there were no other dairy items available to serve to the residents. Observation of the lunch meal on 12/10/24 from 11:55am to 12:15pm revealed: -There were 22 residents in the dining room. -The residents were served chili, cornbread, okra, peaches, water, iced tea and coffee. -Milk was not offered and no dairy items were served. Observation of the lunch meal on 12/11/24 from 12:00pm to 12:15pm revealed: -There were 22 residents in the dining room. -The residents were served spaghetti with meatballs, Caesar salad, wheat roll, pineapple chunks, iced tea, water and coffee. -Milk was not offered and no dairy items were served. -At 12:15pm three residents had left the dining room and had not been offered milk or a dairy item. Observation of the breakfast meal on 12/13/24 at 8:30am revealed: -There were 22 residents in the dining room.	{D 299}		

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{D 299}	Continued From page 130 -The residents were served scrambled eggs, oatmeal, sausage, toast with jelly, juice, water and coffee. -Seven residents out of the 21 residents in the dining room had glasses of milk at their place settings. -None of the other residents were offered or served milk and a dairy item was not served. Interview with a resident on 12/10/24 at 8:09am revealed: -He was served milk once daily. -He liked milk and would drink it more often if it was provided. -He had not had much milk to drink since he was admitted about two years ago. Interview with a second resident on 12/10/24 at 8:15am revealed: -He was not served milk to drink. -He liked to drink milk. -He did not recall the last time milk was provided. Interview with a third resident on 12/10/24 at 8:22am revealed: -He had been at the facility for about two years. -He did not recall ever being served milk to drink. -He liked milk and would drink milk if it was offered. Interview with a fourth resident on 12/10/24 at 8:30am revealed: -He liked milk to drink. -Milk was served yesterday, 12/09/24. -Milk was not served today, 12/10/24. -He thought the facility might have needed to go shopping for milk today, 12/10/24. Interview with the cook on 12/13/24 at 2:33pm revealed:	{D 299}		

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{D 299}	Continued From page 131 -Milk was served to residents at breakfast; certain residents wanted it. -None of the residents asked for milk at lunch or dinner. -When she served meals in the dining room, she offered milk to the residents. -The staff offered milk to the residents when they served meals; if they did not offer the last few times they just forgot. -There was always plenty of milk to drink. Interview with the Supervisor on 12/13/24 at 8:38am revealed: -Milk was purchased by the gallon from the store twice a week; about six gallons was purchased on Mondays. -The cook used the milk to cook with. -Milk was offered at lunch and dinner but not at breakfast because they knew who liked it and who did not. -Some residents would ask for milk at breakfast for their oatmeal or their coffee. -They knew who liked milk so they would offer it to them at lunch and dinner; they did not walk around with a gallon of milk and ask residents if they wanted milk. Interview with the Director on 12/16/24 at 11:46am revealed: -The staff offered residents milk at every meal. -She saw them offer the residents milk when she would pass through the dining room during at least one meal a day. -Sometimes she was not in the dining room when it was offered to the residents. -She did not ask the residents if they were offered milk; she asked the staff and they would say "yes" they did. -She purchased 8 to 9 gallons of milk a week. -She knew milk was to be offered when there was	{D 299}		

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MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 299}	Continued From page 132 not a dairy item on the menu. Interview with the Administrator on 12/16/24 at 3:40pm revealed: -He observed meals once or twice a month. -He passed by the dining room and asked the residents how everything was. -He was not involved in depth with the meals; the cook and the Director were responsible for the meals. -Milk should have been offered three times a day if there was no dairy items on the menu.	{D 299}		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve supplements as ordered for 1 of 1 sampled residents (#8) who had an order for a nutritional supplement. The findings are: Review of Resident #8's current FL-2 dated 11/08/23 revealed diagnoses included metabolic encephalopathy, asthma, dementia, muscle weakness and constipation. Review of Resident #8's signed physician orders dated 11/08/23 revealed: -There was an order for a "house supplemental	D 310		

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shake" three times daily away from meals.
-There was no order to obtain daily, weekly, or monthly weights.

Observation of the 9:00am medication pass on 12/10/24 revealed the medication aide (MA) did not administer a nutritional supplement to Resident #8.

Review of Resident #8's October 2024 paper medication administration record (MAR) from 10/10/24 to 10/31/24 revealed:
-There was an entry for one nutritional supplement three times daily away from meals with a scheduled time of 9:00am, 3:00pm, and 9:00pm.
-There was documentation a nutritional supplement was administered three times daily away from meals.

Review of Resident #8's November 2024 electronic medication administration record (eMAR) from 11/01/24 to 11/30/24 revealed:
-There was an entry for one nutritional supplement three times daily away from meals with a scheduled time of 9:00am, 3:00pm, and 9:00pm.
-There was documentation a nutritional supplement was administered 10 times out of 90 opportunities.
-There were 80 exceptions documented; the exceptions were resident refused, out of the facility, and physically unable to take.

Review of Resident #8's December 2024 eMAR from 12/01/24 to 12/10/24 revealed:
-There was an entry for one nutritional supplement three times daily away from meals with a scheduled time of 9:00a, 3:00pm, and 9:00pm.

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-There was documentation a nutritional supplement was administered 1 time out of 37 opportunities.
-There were 39 exceptions documented; the exceptions were resident refused and physically unable to take.

Observation of the breakfast meal on 12/13/24 at 8:30am revealed:
-The residents were served scrambled eggs, oatmeal, sausage, a slice of toast, jelly, juice, water and coffee.
-Resident #8 removed the crust from her slice of toast.
-She ate 100 percent of her slice of toast with the crust removed, and 100 percent of her scrambled eggs.
-She did not eat her oatmeal or her sausage.
-She was not served a nutritional supplement.

Observation of the lunch meal on 12/13/24 at 11:45am revealed:
-The residents were served a salmon patty, coleslaw, cornbread and fruit with water, iced tea and coffee.
-Resident #8 ate 100 percent of her cornbread and fruit.
-She ate less than half of her salmon patty and none of her coleslaw.
-She was not served a nutritional supplement.

Observation of Resident #8's room on 12/10/24 and 12/13/24 between 8:00am and 5:00pm revealed there were no nutritional supplements available for administration.

Observation of Resident #8 being weighed on 12/16/24 at 11:14am revealed:
-Resident #8 ambulated to a storage room where the chair scales were stored.

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D 310	Continued From page 135 -Resident #8 was fully dressed and weighed 97.5 pounds. Review of Resident #8's monthly weight log from January 2024 to November 2024 revealed: -The log was for one year. -The log had five columns; the first column was for each month, the second for documenting the weight, the third the pounds lost or gained within one month, the fourth for pounds lost or gained within 6 months and the fifth for percentage of weight lost or gained. -The instructions on the bottom of the log instructed to indicate a plus for weight gain and a minus for weight loss. -There were instructions to determine the amount of weight loss by dividing the number of pounds gained or lost by the previous weight. -Resident #8 was documented as weighing 110 pounds in January, February, July, October, and November 2024; 108 pounds in April 2024 and 109 pounds in May 2024; weights were refused in March, June and September 2024. -There was no date documented to indicate what day of the month the weights were taken and there was only one date per month. -Based on Resident #8's documented weight on the weight log, Resident #8 had an 11 percent weight loss from November 2024 to 12/13/24. Interview with Resident #8 on 12/16/24 at 10:00am revealed: -She used to drink a nutritional supplement several times a day. -She had not had a nutritional supplement in a long time. -She thought her family member brought them to her. Telephone interview with Resident #8's family	D 310		

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member on 12/16/24 at 10:32am revealed:
-She brought Resident #8 snacks and cigarettes.
-She used to bring Resident #8 nutritional supplement , but they were so expensive she stopped bringing them.
-It had been months since she brought any nutritional supplements to Resident #8.
-She thought she told the Director she could no longer afford the nutritional supplements .

Interview with the cook on 12/13/24 at 8:34am revealed:
-Resident #8 usually did not eat all of her meal.
-The family would bring her snacks to eat.
-She liked to eat sweets.
-Resident #8 looked like she had lost some weight.

Interview with a personal care aide (PCA) on 12/16/24 at 10:56am revealed:
-She did not weigh Resident #8.
-She did not know who weighed Resident #8 or how often Resident #8 was weighed.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 12/11/24 at 2:04pm revealed:
-Resident #8 had an order for nutritional supplement three times daily away from the meal.
-The pharmacy did not supply Resident #8 with nutritional supplement.
-The pharmacy could supply Resident #8 with nutritional supplements, but the facility staff would have to call and request them.

Telephone interview with a MA on 12/16/24 at 11:15am revealed:
-Resident #8 had not had nutritional supplements in a long time.
-Resident #8's family member would bring the

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nutritional supplements.
-The family was aware Resident #8 did not have any nutritional supplements in the facility.
-The Director was aware Resident #8 did not have any nutritional supplements ; the Director was going to notify the primary care provider (PCP).
-The MA did not weigh residents; she did not know how to use the chair scales.

Interview with the Supervisor on 12/16/24 at 11:14am revealed:
-She weighed Resident #8 today, 12/16/24, at the request of the surveyor.
-She did not weigh residents; the residents were weighed by the PCP when they visited.

Interview with the Director on 12/16/24 at 5:03pm revealed:
-Resident #8's family brought nutritional supplements to Resident #8.
-She did not know Resident #8 did not have any nutritional supplements and that the family had stopped bringing them to the facility.
-No one had notified her that Resident #8 was not getting nutritional supplements.
-Resident #8 did not have an order for weights.
-When the PCP did not order weights, the facility would weigh the residents monthly.
-The MAs were responsible for obtaining the weights each month.
-Resident #8 ate 100 percent of her meals.
-The PCP should be notified for a weight loss of 3 pounds or more.
-Resident #8 did not have an order to notify the PCP of weight loss and the facility did not have a policy regarding weight loss.
-She remembered a previous order for another resident was to notify the PCP of weight loss of 3 pounds, so that was how she decided on the

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D 310	Continued From page 138 number of pounds lost and when to notify the PCP. -They did not have a current PCP to notify for Resident #8's weight loss. -Resident #8 would be taken to an urgent care or the emergency department (ED) if she needed to be seen by a physician. -The dietary staff could give her extra food at mealtimes, especially food that she likes, and offer her additional snacks. Telephone interview with the Administrator on 12/17/24 at 2:53pm revealed: -He did not know who supplied Resident #8 with the nutritional supplements. -The MAs should notify the PCP if the nutritional supplements were not available. -He expected the MAs to serve nutritional supplements as ordered. -He expected the Director to ensure there were nutritional supplements in the facility for Resident #8. -Resident #8 did not look like she had lost any weight; Resident #8 looked the same to him. -He did not think Resident #8's weight was accurate. -The PCP should be notified of Resident #8's weight loss. -There was no current PCP to notify. -Resident #8 would have to go to the ED related to her weight loss. Attempted telephone interviews with Resident #8's PCP on 12/13/24 at 10:09am and on 12/16/24 at 9:00am were unsuccessful.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights	D 338		

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D 338	Continued From page 139 An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to maintain an environment in which the residents were protected from physical and verbal abuse as evidenced by Staff B and C hitting a resident (#10), Staff B and D cursing at multiple residents, Resident #7 being hit by staff, multiple residents sprayed with water by staff members; and 1 of 1 sampled resident (#11) who was denied a reasonable response when he requested a roommate change when the roommate displayed sexual behaviors and poor hygiene. The findings are: 1. Confidential interview with a resident revealed: -Sometimes the staff was good and sometimes the staff was bad. -Staff were bad because they pulled on residents and would "snatch" residents by the arm. -When the staff wanted the resident "to come on" they would pull on the resident. -This resident had water thrown in their face before. -The resident had been "pushed out" of the dining room. -The staff cursed at the residents all the time. -The resident would not say who the "staff" were. Confidential telephone interview with a resident's family member revealed:	D 338		

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-She had heard staff curse at the residents.
-She had heard "all of the staff" curse at the residents.
-She had heard the staff tell a resident, "I will whoop your [expletive]."
-She had heard the staff tell a resident to get in there and sit your [expletive] down.
-She had heard the staff tell a resident you are not getting [expletive].

Interview with a resident on 12/10/24 at 8:44am revealed:
-Multiple staff cursed "him out."
-When staff cursed at him it made him want to go to the hospital."
-Staff B and Staff D cursed at the residents.
-The staff members would tell the residents every day to "shut the [expletive] up."
-It made his heart beat "really fast" when the staff cursed at the residents.
-The staff members had tried to hit him before, but he argued back.

Interview with a second resident on 12/10/24 at 8:59am revealed:
-Staff members yelled at the residents.
-The staff stated, "I am tired of y'all."
-It hurt his feelings when the staff hollered.
-He was trying to move away from the facility because of the way he was treated by the staff.

Interview with a third resident on 12/10/24 at 9:10am revealed:
-Sometimes staff squirted the residents with water.
-The squirt bottle was used to make "us not say bad things."
-One of the staff was a MA and the other was a cook.
-The staff had never hit him.

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-The staff members would say they were going to "knock the [expletive] out of you."
-The staff members had told him they were going to "knock him silly", and they were going to "knock him into next week."
-The last time it happened was on Thanksgiving day.
-The staff members would hurt the residents; the staff did not want the residents to talk to the surveyors.

Interview with a fourth resident on 12/10/24 at 11:14am revealed:
-Staff cursed the residents all the time.
-He had seen the MAs and the cook curse the residents.
-Staff squirted residents with water if the resident was talking when the staff had told the resident to be quiet.
-It made him feel bad the way the staff treated the residents.

Interview with a fifth resident on 12/10/24 at 11:45am revealed:
-Staff members were cursing the residents yesterday.
-When asked which staff he stated, "All of them."
-He had seen staff squirt water on residents.
-It made him feel bad the way the staff treated the residents.

Interview with a sixth resident on 12/10/24 at 1:21pm revealed:
-Staff told the residents, loudly, to eat and get out of the dining room.
-He heard staff curse the residents every week.
-He ate fast and left the dining room quickly, so he did not have to listen to it.
-He had seen staff members squirt residents with water every once in a while, but he did not know

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D 338	Continued From page 142 why. Interview with a seventh resident on 12//10/24 at 1:31pm revealed: -Staff cursed the residents if the staff had told a resident to do something and the resident did not do it. -He had seen staff members squirt residents with a water bottle, like out of a cleaning bottle. -It made him feel sad the staff treated people the way they did. -He prayed about it for the residents it happened to. Interview with an eighth resident on 12/11/24 at 11:39am revealed: -He heard yelling up and down the hall all the time, even at 2:00am. -He did not know if the yelling was staff or residents or both. -There was conflict "around here all the time." -Residents and staff were hollering and cursing all the time. Interview with a ninth resident on 12/10/24 at 12:03pm revealed: -About 2-3 weeks ago, he saw a staff member grab a male resident by his arm and restrain the resident. -He did not know why the male resident was being restrained. -He saw the cook tap a male resident on the head with a ruler, but he thought the staff member was "playing." Interview with the facility's contracted licensed clinical social worker (LCSW) on 12/10/24 at 1:56pm revealed: -Her visits with the residents were confidential. -A resident shared with her how the staff talked	D 338		

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down to the resident and it made the resident mad.
-It was about two months ago when the resident shared this with her.
-She only saw nine of the residents at the facility.

2. Review of Resident #7's current FL-2 dated 07/07/24 revealed:
-Diagnoses included schizoaffective disorder, diabetes, chronic pain, and migraines.
-She was intermittently disoriented.

Confidential interview with a resident revealed:
-The resident observed Resident #7 being hit "all the time."
-The resident did not recall the last time staff members hit Resident #7, but it happened all the time.
-The resident had observed staff members hit Resident #7 in the face and "anywhere they could."
-The resident was afraid if they said anything the staff members would start hitting them.
-The resident would not say who the "staff" were.

Interview with a resident on 12/10/24 at 8:44am revealed he had seen multiple staff members punch Resident #7 in the face; he saw it last month.

Interview with a second resident on 12/10/24 at 9:10am revealed he had seen staff members hit Resident #7.

Interview with a third resident on 12/10/24 at 11:37am revealed:
-He had seen staff grab Resident #7 and drag the resident across the floor.
-This happened in the living room about 3-4 weeks ago.

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D 338	Continued From page 144 Interview with a fourth resident on 12/10/24 at 11:45am revealed he had seen staff squirt water on Resident #7. Interview with a fifth resident on 12//10/24 at 1:31pm revealed he had seen staff members hit Resident #7. Interview with Resident #7 on 12/10/24 at 4:22pm revealed she would like to be treated nicely. Telephone interview with Resident #7's family member on 12/11/24 at 9:24am revealed: -When she asked Resident #7 how things were going, Resident #7 talked about not being happy and people being mean to her. -When she asked Resident #7 for examples, Resident #7 would state Staff C did not like her. -Resident #7 would tell her Staff C would not let her do anything. Telephone interview with Resident #7's former primary care provider (PCP) on 12/11/24 at 4:31pm revealed: -Resident #7 had schizoaffective disorder and had behaviors. -If Resident #7 was having intermittent episodes of behaviors, the facility staff should have called the PCP and not physically or verbally abused the resident. Telephone interview with the facility's contracted mental health provider (MHP) on 12/12/24 at 11:59am revealed Resident #7 had reported to her she did not get along with some of the staff. 3. Review of Resident #10's current FL-2 dated 07/27/24 revealed: -Diagnosis included dementia.	D 338		

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D 338	Continued From page 145 -He was intermittently disoriented. Interview with a resident on 12/10/24 at 8:44am revealed he had seen multiple staff members hit Resident #10, most recently last month. Interview with a second resident on 12/10/24 at 9:10am revealed he had seen staff hit Resident #10. Interview with a third resident on 12/10/24 at 11:37am revealed he had seen staff hit Resident #10 with a stick and a ruler. Interview with a fourth resident on 12/10/24 at 11:45am revealed: -He saw staff hit Resident #10 yesterday, 12/09/24. -Resident #10 had dementia "really bad" and staff cursed at the resident, telling Resident #10 to find his [expletive] room. -Two days ago, he saw a staff member hit Resident #10 with a ruler. Interview with a fifth resident on 12/10/24 at 1:21pm revealed: -He had seen Staff B hit Resident #10. -He had not seen Resident #10 do anything, so he did not know why the cook hit the resident. -He saw Staff C hit Resident #10 with a ruler. -He felt bad for Resident #10 because "it could be me." Interview with a sixth resident on 12//10/24 at 1:31pm revealed he had seen staff members hit Resident #10. Interview with Resident #10 on 12/11/24 at 11:14am revealed: -He had lived at the facility "too long."	D 338		

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-Staff members had sprayed water on him.
-When asked why the staff sprayed water on him, he replied, "to see what he would do."
-He did not do bad things to people.
-Staff told him to sit down and he sat down.
-Staff knew to not hit him because he would hurt them.

Interview with the Director on 12/10/24 at 4:37pm revealed:
-Resident #10 said no woman was going to tell him what to do.
-She had not heard anything about Resident #10 being hit with a ruler.

Telephone interview with the Administrator on 12/13/24 at 2:31pm revealed he did not believe anyone had done anything to Resident #10, because the resident was aggressive and would not allow anyone to do anything to him.

_____

Interview with the facility's contracted licensed clinical social worker (LCSW) on 12/10/24 at 1:56pm revealed:
-Her visits with the residents were confidential.
-A resident shared with her how the staff talked down to the resident and it made the resident mad.
-It was about two months ago when the resident shared this with her.
-She only saw nine of the residents at the facility.

Interview with Staff D on 12/10/24 at 4:31pm revealed:
-She had not seen any staff curse at residents, hit residents, hit residents with a ruler/stick, or spray water on residents.
-She had not heard any residents complain that they had been cursed, hit, or sprayed with water.
-She had not cursed at any residents, hit a

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resident, or sprayed water on a resident.

Interview with a second MA on 12/13/24 at 9:04am revealed:
-She had never seen or heard staff raise their voices at residents, curse residents, or hit residents.
-She had not heard any resident complain that anyone had done these things.

Interview with the Staff C on 12/10/24 at 4:34pm revealed:
-She had not seen any staff curse at residents, hit residents, hit residents with a ruler/stick, or spray water on residents.
-She had not heard any residents complain that they had been cursed, hit, or sprayed with water.
-She had not cursed at any residents, hit a resident, or sprayed water on a resident.

Interview with a personal care aide (PCA) on 12/11/24 at 8:43am revealed:
-She had never seen staff "be ugly" to the residents.
-She had never heard any residents complain of staff being mean.

Interview with a second PCA on 12/11/24 at 6:59pm revealed:
-She worked 7:00pm-7:00am by herself.
-She usually did not see other staff interact with the residents because when she came in, the other staff were leaving.
-No residents had told her about staff cursing the residents, hitting the residents, or spraying the residents with water.

Interview with Staff B on 12/12/24 at 4:24pm revealed:
-She had not heard any staff curse at the

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residents, hit a resident, or squirt water on a resident.
-She had not cursed at a resident, hit a resident, or squirted water on a resident.

Telephone interview with the facility's contracted mental health provider (MHP) on 12/12/24 at 11:59am revealed:
-What she had seen staff do was talk to the residents as if the residents were their "own" children, sternly.
-She wondered if that may be what the residents were talking about because of the tone and the way the staff spoke to the residents.

Telephone interview with the facility's former primary care provider (PCP) on 12/11/24 at 4:31pm revealed:
-Mistreating the residents would make the residents behaviors worse, not better.
-It was morally wrong to mistreat the residents.

Interview with the Director on 12/10/24 at 4:37pm revealed:
-The only hitting she was aware of was residents hitting staff members.
-She had not heard anything about any resident being sprayed with water.
-She had not observed or heard staff curse at residents.
-No residents had come to her to report being cursed, hit, or sprayed with water by staff.
-She was concerned because that kind of behavior was not "humanly correct".
-"That was just not right."
-She had worked with Staff B, Staff C, and Staff D, and it was hard to believe.
-It broke her heart the residents did not come to her unless the residents thought the bad treatment might get worse.

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D 338	Continued From page 149 -Her job was to protect the residents. Telephone interview with the Administrator on 12/13/24 at 2:31pm revealed: -He had not heard of the allegations until the Director told him. -If there was anything like this going on, the residents would tell him or the Director. -It was hard for him to believe the allegations had happened. -It would be unacceptable if the allegations were true. Interview with the Administrator on 12/16/24 at 5:49pm revealed: -An accusation was an accusation. -If he had known of the accusations, he could have checked to see who was guilty or not. -If a resident had something in their mind, the resident believed it was true even if it was not. _____ 4. Review of Resident #11's current FL-2 dated 11/26/24 revealed diagnoses included acute respiratory failure requiring intubation, breakthrough seizure, generalized tonic-clonic seizures, prolactinoma, status epilepticus, history of traumatic brain injury, cognitive developmental delay, chronic static encephalopathy, and intellectual disability with epilepsy. Observation of Resident #11's bedroom on 12/10/24 at 8:10am revealed: -There was a heavy odor of urine and bowel movement. -There was a trashcan that was over filled and contained a wet adult brief. -There was flooring beside the bed of Resident #11's roommate that was wet.	D 338		

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D 338	Continued From page 150 Interview with Resident #11 on 12/16/24 at 8:25am revealed: -His roommate moved into the room about a year ago. -He was in the room first and the roommate was moved into the room with him. -He did not want to be around his roommate. -His roommate would touch himself under the covers while Resident #11 was in the room. -He had been awakened to his roommate rubbing him on his back. -His roommate had tried to touch him below the waist while he was sleeping. -He woke up and his roommate was standing beside his bed acting like he was going to hit him; his fist was balled up and pulled back. -His roommate had gotten worse after a recent hospital visit about two months ago. -He would tell his roommate to leave him alone. -He complained to the Director and the Supervisor right after the first time it happened. -They told him they would do something about it, but they did nothing. -He had "been asking and asking them" to get him a new roommate for longer than two months. -They did nothing; they just let it go. -He went to the Administrator after he spoke to the Director and the Supervisor because they did nothing. -He did not recall what the Administrator had said to him. - "It looked like the Administrator was not going to do anything either ". -It made him ill to be around his roommate -It hurt his feelings because no one did anything about it. -He did not want to be touched and his roommate wanted to touch him. -He would be okay with another roommate. -He had talked to his guardian about a new	D 338		

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roommate and why he wanted a new one.
-The guardian told him it was okay to get a new roommate or to change rooms.
-He did not know if his guardian spoke to someone.
-His roommate was supposed to use adult briefs, but he did not.
-His roommate urinated on the floor and had bowel movements in his bed, so the room smelled bad.
-His roommate had poop on his shoes.
-His room always smelled "really bad" because of his roommate.

Interview with a personal care aide (PCA) on 12/16/24 at 6:55pm revealed:
-About a month ago Resident #11 told her his roommate was touching himself while he was in the room.
-She reported Resident #11's complaints to the Supervisor about a month ago.
-When she reported it to the Supervisor, she said "they were aware of it".
-She did not ask what the facility was going to do about the complaint.
-When Resident #11 would come to her and tell her his roommate was touching himself, she would let Resident #11 sleep on the sofa in the common area because he did not want to be in the room when his roommate was in the room "doing that".

Interview with the Supervisor on 12/16/24 at 11:30am revealed:
-Resident #11 had not spoken to her about moving out of his room.
-He had complained about his roommate snoring but nothing major to her.
-Resident #11 would say his roommate touched with himself in the room when he was in there.

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D 338	Continued From page 152 -That had been about two or three months ago. -She asked the roommate about the complaint and he did not know anything about it. -She told the Director after Resident #11's complained about his roommate touching with himself. -She did not know what was done and he only complained to her the one time. -She thought the roommate was in the room first and Resident #11 moved in because he did not get along with his previous roommate. -They had been roommates for about a year. -Resident #11 had never complained about his roommate's hygiene or odors in his room. Interview with the Director on 12/16/24 at 11:46am revealed: -Resident #11 had been in the room first; he and the roommate had roomed together for about a year. -Resident #11's roommate had a diagnosis of paraphilia (a condition characterized by intense and persistent sexual arousal) and was incontinent. -There had been issues with the roommate going into a female resident's room and sitting on her bed about a year ago but there had been no issues in the last year. -The staff kept an eye on the roommate so there was no temptation; they made sure he did not wander into female residents' rooms. -Resident #11 complained of his roommate touching with himself a couple of months ago. -Resident #11 told her his roommate was "nasty" and he touched with himself. -He had complained about his roommate more than once to her. -She told Resident #11 to leave the room when his roommate was touching himself because it was mostly during the day when it happened.	D 338		

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D 338	Continued From page 153 -Resident #11 requested a new roommate or to change rooms. -Resident #11 had been asking to move out of the room since before November 2024. -Resident #11 said he wanted a new roommate because the roommate was always in his "stuff" and he smelled bad. -She asked Resident #11 if he told his roommate he smelled and needed a shower; he told her no. -The roommate smelled because he was incontinent and just smelled like urine; he smelled better after he took his shower. -The roommate wet the bed because he pulled his own adult brief down in the middle of the night. -She was not aware of any bowel movement incidents in the bed; she thought he always made it to the bathroom. -Resident #11 complained because he just wanted to move out; he only complained of the smell after his roommate urinated on himself or had an accident. -Resident #11 would ask for a private room and then change his mind and want a roommate. -When he requested to move out, she would tell him to let her check into it and get back. -He had not requested to move out since his last hospital visit. -She had not moved Resident #11 because he had other roommates and had been moved before. -Resident #11 had told her "about" his roommate touching himself but not about the roommate touching Resident #11. -Resident #11 had not told anyone about his roommate touching him. -She would have moved the roommate and started an investigation if there had been a complaint of touching.	D 338		

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D 338	Continued From page 154 Interview with the Administrator on 12/16/24 at 3:50pm revealed: -Resident #11 had multiple roommates and they never worked out. -If Resident #11 did not get his way he acted out. -He threw his walker at a staff the other day. -He had been moved multiple times; he had roommates and had also roomed alone. -He had spoken with Resident #11 last week about him not wanting "this roommate". -Resident #11 did not give a reason why he did not want this roommate. -He figured Resident #11 just did not like him. -It was hard to find a roommate for Resident #11; he could not tell how many roommates he had. -His roommate was quiet, stayed to himself and did not have behaviors. -Resident #11 was in everyones' business and his situations with his roommate were a constant roller coaster. -Resident #11 had not complained or told him of his roommate touching with himself. -Resident #11 had never complained about anyone touching him in the past. -Resident #11 should have told him or the Director about the roommate touching himself; he would have found a better solution. -If Resident #11 had told the Director or him about his roommate attempting to touch him there would have been an investigation. -If Resident #11 had complained to staff, he expected them to come to the Director or him with the information. -If Resident #11's roommate had touched him, he would have reacted; there would have been a "large" reaction because that was the way Resident #11 was. -He did not know how long Resident #11 had been sharing the room with his current roommate.	D 338		

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D 338	Continued From page 155 -He did not think Resident #11 would have any problems coming to him and talking to him about anything. -When Resident #11 had complained about wanting a new roommate in the past, he would have a discussion with Resident #11, and he thought Resident #11 was okay. Attempted telephone interview with Resident #11's guardian on 12/16/24 at 9:45am was unsuccessful. Attempted telephone interview with Resident #11's mental health provider (MHP) on 12/16/24 at 10:31am was unsuccessful. _____ The facility failed to ensure residents were free from verbal and physical abuse. Staff B and Staff C physically abused a resident (#10), multiple residents were cursed at by Staff B and Staff D and multiple residents were sprayed with water resulting in the residents feeling bad and anxious about the way the staff treated them. This failure resulted in abuse and neglect to the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/24. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 16, 2025.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for	D 344		

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medications and treatments:
(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure contact with the resident's prescribing practitioner for clarification of medication orders for 3 of 4 sampled residents (#2, #3, #5) including an antibiotic, two supplements, eye drops, nasal spray, a stool softener, and an anti-itch lotion (#2), a stool softener (#3).

The findings are:

1. Review of Resident #5's current FL-2 dated 09/21/24 revealed:
-Diagnosis included diabetes mellitus.
-There was an order to check and record fingerstick blood sugar (FSBS) prior to giving any/all insulins; hold for FSBS less than 100.
-There was an order for Lantus 55 units (a long acting insulin) subcutaneously (SQ) daily.
-There was an order for Novolog (a fast acting insulin) sliding scale insulin (SSI) three times daily with meals.

Review of Resident #5's October 2024 medication administration record (MAR) from 10/10/24 to 10/31/24 revealed:
-There was an entry to check and record FSBS

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prior to giving any/all insulins; hold insulin for FSBS readings less than 100 with a scheduled time of 7:30am, 11:30am, 4:30pm, and 7:30pm.
-There was an entry for Novolog SSI three times daily with meals.
-There was documentation Novolog SSI was administered from 10/10/24 to 10/28/24 and on 10/30/24 at 7:30am, 11:30am and 4:30pm; and on 10/29/24 and 10/31/24 at 7:30am.
-There was no documentation Novolog was administered on 10/29/24 and on 10/31/24 at 8:00pm; the MAR was blank.
-There was an entry for Lantus 55 units SQ with a scheduled administration time of 8:00pm.
-There was documentation Lantus 55 units was administered from 10/01/24 to 10/27/24, and on 10/30/24 at 8:00pm;
-There was no documentation Lantus 55 units was administered on 10/28/24, on 10/29/24 and on 10/31/24 at 8:00pm; the MAR was blank.
-There was no documentation of FSBS readings to indicate if the Novolog insulin and/or the Lantus insulin should be held.

Review of Resident #5's November 2024 electronic medications administration record (eMAR) from 12/01/24 to 12/10/24 revealed:
-There was an entry to check and record FSBS prior to giving any/all insulins; hold insulin for FSBS readings less than 100 with a scheduled time of 7:30am, 11:30am, 4:30pm, and 7:30pm.
-There was an entry for Lantus 55 units SQ with a scheduled administration time of 8:00pm.
-There was documentation Lantus 55 units was administered from 11/01/24 to 11/08/24 and from 11/10/24 to 11/30/24 at 8:00pm.
-There was documentation Lantus was not administered on 11/09/24; the exception was physically unable to take.

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MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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Review of Resident #5's December 2024 eMAR from 12/01/24 to 12/10/24 revealed:
-There was an entry to check and record FSBS prior to giving any/all insulins; hold insulin for FSBS readings less than 100 with a scheduled time of 7:30am, 11:30am, 4:30pm, and 7:30pm.
-There was documentation on 12/06/24 at 7:30pm of a FSBS reading of 94.
-There was an entry for Lantus 55 units SQ with a scheduled administration time of 8:00pm.
-There was documentation Lantus 55 units was administered on 12/06/24 at 8:00pm.

Interview with a medication aide (MA) on 12/12/24 at 2:41pm revealed:
-She held all of Resident #5's insulins if Resident #5's FSBS reading was 85.
-She had held the fast-acting and the long-acting insulin when Resident #5's FSBS was below 85.
-When asked why insulin was held with a FSBS reading of 85 or below, the MA did not respond.

Telephone interview with a second MA on 12/17/24 at 11:15am revealed:
-She held all insulins for Resident #5 if her FSBS readings were below 100.
-She held the Lantus insulin if the FSBS was below 100; she documented incorrectly on 12/06/24.
-She could not recall what Resident #5's FSBS readings were in October 2024 or if she held any insulin.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 12/16/24 at 12:34pm revealed:
-The pharmacy did not enter orders for FSBS checks unless the order was written with an insulin administration order.
-She was not sure which insulin should be held or

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if both insulins should be held; the order was not associated with an insulin.
-The pharmacy had not received any notifications from the facility to clarify this order.
-The facility staff should have called the primary care provider (PCP) to clarify the order.

Telephone interview with a representative at Resident #5's primary care provider's (PCP) office on 12/16/24 at 11:52pm revealed:
-She did not know why Resident #5's insulin order was written the way it was.
-No one from the facility had notified the PCP office for clarification of the order.
-The PCP would have to clarify the order.

Interview with the Director on 12/16/24 at 5:03pm revealed:
-The MAs could not determine which insulin to hold for a low FSBS reading; the order was not clear.
-The MA should have called the PCP office to clarify the order.

Telephone interview with the Administrator on 12/17/24 at 2:53pm revealed the MAs should have clarified the order to ensure the correct insulin was held when Resident #5's FSBS reading was below 100.

2. Review of Resident #2's current FL-2 dated 09/10/24 revealed:
-Diagnoses included hypertension and peripheral artery disease.
-There was no order for Clindamycin (an antibiotic) 300mg three times daily, Potassium Chloride (a supplement used to treat and prevent low blood potassium) ER 20meq extended-release (ER) take one tablet once daily, Vitamin D3 (a supplement used to treat and

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prevent bone disorders) 25mcg (1,000 unit) take one tablet once daily, Artificial tears (used to lubricate dry eyes) 1% eye drops, instill 2 drops in both eyes three times daily, Fluticasone Propionate (used to relieve sneezing, itchy or runny nose) 50mcg/actuation nasal spray, suspension, spray one spray in each nostril every morning, Docusate Sodium (used to treat and prevent constipation)100mg, take one capsule twice daily and Sarna lotion (anti-itch cream) 0.5% apply to itchy skin twice daily.

Review of Resident #2's September 2024 medication administration record (MAR) from 09/10/24-09/30/24 revealed:
-There was an entry for Clindamycin HCL (no other information documented) with a scheduled administration time of 7:00am, 3:00pm, and 11:00pm.
-Clindamycin was documented as administered at 7:00am, 3:00pm and 11:00pm from 09/10/24-09/18/24.
-There was an entry for Potassium Chloride ER 20meq ER once daily with a scheduled administration time of 9:00am.
-Potassium Chloride was documented as administered at 9:00am from 09/10/24-09/20/24 and on 09/26/24.
-There was an entry for Vitamin D3 once daily with a scheduled administration time of 9:00am.
-Vitamin D3 was documented as administered at 9:00am from 09/10/24-09/20/24 and on 09/26/24.
-There was an entry for artificial tears two drops in each eye three times daily with a scheduled administration time of 9:00am, 3:00pm, and 9:00pm.
-Artificial tears were documented as administered at 9:00am, 3:00pm, and 9:00pm from 09/10/24-09/20/24 and at 9:00pm on 09/23/24, 09/25/24, and 09/26/24.

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D 344	Continued From page 161 -There was an entry for Fluticasone Nasal Spray once daily with a scheduled administration time of 9:00am. -Fluticasone nasal spray was documented as administered at 9:00am from 09/10/24-09/20/24. -There was an entry for Docusate Sodium 100mg, one tablet, twice daily with a scheduled administration time of 9:00am and 9:00pm. -Docusate Sodium was documented as administered twice daily at 9:00am and 9:00pm from 09/10/24-09/20/24 and at 9:00pm on 09/22/24 and 09/25/24, and at 9:00am and 9:00pm on 09/26/24. -There was an entry for Sarna lotion twice daily to affected area for itchy skin with a scheduled application time of 9:00am and 9:00pm. -Sarna lotion was documented as applied at 9:00am from 09/10/24-09/18/24 and at 9:00pm from 09/14/24-09/17/24. Review of Resident #2's October 2024 MAR from 10/01/24-10/15/24 revealed: -There was an entry for Potassium Chloride ER 20meq ER once daily with a scheduled administration time of 9:00am. -Potassium Chloride was documented as administered at 9:00am from 10/01/24-10/15/24. -There was an entry for Vitamin D3 once daily with a scheduled administration time of 9:00am. -Vitamin D3 was documented as administered at 9:00am from 10/01/24-10/15/24. -There was an entry for artificial tears two drops in each eye three times daily with a scheduled administration time of 9:00am, 3:00pm, and 9:00pm. -Artificial tears were documented as administered at 9:00am, 3:00pm, and 9:00pm from 10/01/24-10/15/24. -There was an entry for Fluticasone Nasal Spray once daily with a scheduled administration time of	D 344		

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9:00am.
-Fluticasone nasal spray was documented as administered at 9:00am from 10/01/24-10/15/24.
-There was an entry for Docusate Sodium 100mg, one tablet, twice daily with a scheduled administration time of 9:00am and 9:00pm.
-Docusate Sodium was documented as administered twice daily at 9:00am and 9:00pm from 10/01/24-10/15/24.
-There was an entry for Sarna lotion twice daily to affected area for itchy skin with a scheduled administration time of 9:00am and 9:00pm.
-Sarna lotion was documented as administered at 9:00am from 10/01/24-10/15/24.

Review of Resident #2's after-visit summary dated 10/15/24 revealed:
-Medication list included Potassium Chloride ER 20meq extended-release (ER) take one tablet once daily, Vitamin D3 25mcg (1,000 unit) take one tablet once daily, Artificial tears 1% eye drops, instill 2 drops in both eyes three times daily, Fluticasone Propionate 50mcg/actuation nasal spray, suspension, spray one spray in each nostril every morning, Docusate Sodium 100mg, take one capsule twice daily and Sarna lotion 0.5% apply to itchy skin twice daily.
-There was a note to please set up a 30-day supply of the above and follow up with the Primary Care Provider (PCP) for further refills.

Observation of Resident #2's medications on hand on 12/10/24 at 11:52am revealed:
-There was a punch card for Vitamin D3 dispensed on 11/27/24 for 10 tablets; 7 tablets were remaining on the punch card.
-There was a punch card for Docusate Sodium dispensed on 12/01/24; 27 tablets remained on the punch card.
-There was a bottle of artificial tears dispensed on

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09/17/24; the bottle was ¾ full.
-There was a bottle of fluticasone dispensed on 09/17/24; the bottle was ¾ full.
-There was a bottle of Sarna lotion dispensed on 08/09/24; the bottle was ¾ full.
-There was no potassium chloride available to be administered.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/11/24 at 2:04pm revealed:
-The pharmacy had not received a copy of Resident #2's FL-2 dated 09/10/24.
-Resident #2's medications were being filled from prescriptions from July 2024.
-If they had received a copy of Resident #2's FL-2 dated 09/10/24 the medication listed would have been filled.
-Any medication not listed on the FL-2 would be removed from the resident's profile and would not be refilled.
-The pharmacy would reach out to the primary care provider (PCP) to get clarification on any medication that she thought was in error, such as a medication that should have been tapered off and not stopped abruptly.
-The order for the Clindamycin 300mg three times daily would have been clarified because an order for Clindamycin 300mg three times daily for 7-days had been received on 09/06/24.
-Resident #2's medication that would have been discontinued without clarification would have been Vitamin D3, Potassium Chloride, Artificial Tears, Fluticasone, Docusate Sodium, and Sarna lotion because these medications could have been discontinued because the medication was no longer needed.

Interview with a medication aide (MA) on 12/13/24 at 9:04am revealed:

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D 344	Continued From page 164 -She never saw a resident's FL-2 because the Director handled those. -If there were any medication changes the Director would tell the MAs verbally before it was entered on the MAR. -The pharmacy was responsible for entering new orders on the MAR. Interview with another MA on 12/16/24 at 11:00am revealed: -She did not look at a resident's FL-2. -She did not know who was responsible for the orders on a resident's FL-2. Interview with the Director on 12/16/24 at 3:11pm revealed: -She completed new FL-2s based on the previous FL-2 if there had been no changes. -She usually ran the current list of medications from the eMAR and attached it to the FL-2 and documented "see attached". -She had written in the medications on Resident #2's FL-2 dated 09/10/24. -She had not attached current physicians' orders with Resident #2's FL-2, but she could not remove the documentation see attached list when she wrote the orders in. -She did not know she had missed medications listed on Resident #2's eMAR, including Fluticasone, eye drops, anti-itch cream, Vitamin D, and Potassium. -She did not notice she had not put a stop date on Resident #2's Clindamycin. -Once the resident's FL-2 was signed, the FL-2 was filed. -She did not fax FL-2s to the pharmacy, she did not know she needed to. Interview with the Administrator on 12/16/24 at 5:49pm revealed:	D 344		

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D 344	Continued From page 165 -The Director was responsible for completing FL-2s annually on the resident. -Once a FL-2 had been completed and signed by the PCP, the Director should fax the FL-2 to the pharmacy. -The Director should have gotten clarification on any medications that were on the MAR and not on the signed FL-2. -The Director should have gotten clarification on the stop date for Resident #2's Clindamycin. 3. Review of Resident #3's current FL-2 dated 11/06/23 revealed: -Diagnoses included schizophrenia, mild retardation, diabetes mellitus type 2, and hypertension. -There was an order for polyethylene glycol (used to treat constipation) 17gm one dose to drink and hold for loose stools. -There was no frequency on the order. Review of Resident #3's medication administration record (MAR) for October 2024 revealed: - There was an entry for polyethylene glycol 3350 mix 17gm into 8 ounces of water or fluid and drink and hold for loose stools; there was no scheduled time for administration. -There was no documentation Resident #3's polyethylene glycol had been administered the month of October 2024. Review of Resident #3's electronic medication administration record (eMAR) for November 2024 revealed: - There was an entry for polyethylene glycol 3350 mix 17gm into 8 ounces of fluid and drink and hold for loose stools scheduled at 12:00am. -There was no documentation Resident #3's polyethylene glycol had been administered the month of November 2024.	D 344		

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D 344	Continued From page 166 Review of Resident #3's eMAR for December 2024 from 12/01/24 to 12/13/24 revealed: - There was an entry for polyethylene glycol 3350 mix 17gm into 8 ounces of fluid and drink and hold for loose stools scheduled at 12:00am. -There was no documentation Resident #3's polyethylene glycol had been administered the from 12/01/24 to 12/13/24. Observation of Resident #3's medication on hand on 12/10/24 at 2:08pm revealed: -There was an unopened bottle of polyethylene glycol dispensed on 11/27/24 available for administration. -The instructions on the pharmacy label on the bottle were 17gm one dose to drink and hold for loose stools. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/10/24 at 3:20pm revealed: -Resident #3 had an order dated 07/31/24 for polyethylene glycol 17gm in water once daily at 8:00am; hold for loose stools. -A thirty-day supply of polyethylene glycol was dispensed on 11/27/24. -Sometimes the frequency information on the medication label would get cut off. -The complete information would be on the eMAR. Telephone interview with Resident #3's previous primary care provider (PCP) on 12/11/24 at 5:15pm revealed Resident #3 had an order dated 10/22/24 for polyethene glycol 17gm in water once daily as needed (PRN) for constipation. Interview with a medication aide (MA) on 12/12/24 at 10:56am revealed:	D 344		

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D 344	Continued From page 167 -Resident #3's polyethylene glycol order could not be seen on the eMAR because when it came up on the eMAR it was highlighted in red and had "error" on it. -She let the Director know about the error message. -It had only been on the eMAR for a couple of days. -The Director would have it taken care of within a day or so. -She could not administer Resident #3's polyethylene glycol because she could not see the order. Interview with a second MA on 12/13/24 at 9:25am revealed: -She thought Resident #3's polyethylene glycol had been discontinued because it came up blacked out on the eMAR screen. -If the eMAR showed an error on a medication it was because the order was written wrong. -If Resident #3's polyethylene glycol came up as an error she would not administer it and she would let the Director know the order needed to be fixed. -It only took the Director a day to correct the error on the eMAR. -Resident #3 did not have any polyethylene glycol on the medication cart to administer. Interview with the Director on 12/12/24 at 3:15pm revealed: -The pharmacy entered the order on the eMAR for Resident #3's polyethylene glycol. -The MAs checked the orders with the label to see if it was correct on the eMAR. -She was not aware of the error on the eMAR until yesterday when the MA told her about it. -If there was an issue with the medication on the eMAR, it came up as an error in red and the MAs	D 344		

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could not see what the error was.
-She reached out to the pharmacy and they told her to contact the electronic company eMAR system for help, but she could not reach them.
-She did not know the problem with the polyethylene glycol was the order was incomplete and did not have a frequency.
-She did not think to look at the label on the polyethylene glycol to see what the order was.
-She did not know the order was visible on a print out of the eMAR; if she had known she would have printed it out sooner to look for the problem.
-She should have realized the issue when she saw the scheduled time on the eMAR screen was 12:00am; medication would not be scheduled for administration in the middle of the night.
-The MAs should have notified her as soon as there was an error on the eMAR; she thought the error was only on the screen for a few days.
-If she had known sooner, she would have tried to find the error sooner.
-The PCP should have been contacted to find out what the frequency for the medication was and have a new order written to include the information.
-The MAs could call the pharmacy or the PCP, but they may not know they could call.
-She was responsible for contacting the pharmacy or the PCP for clarification of medication orders.

Interview with the Administrator on 12/16/24 at 4:20pm revealed:
-The MAs reported to the Director when there was an error notification on the eMAR.
-They were to report the error reading as soon as they saw it.
-The Director was responsible for reviewing what was wrong with the medication order in the eMAR and correcting it in the eMAR.

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D 344	Continued From page 169 -The Director should have contacted the PCP or the pharmacy for the correct order when she discovered to the error. -The Director would not have known there was an issue with the order or the error until the MAs told her. -He expected the MAs to inform the Director of eMAR errors and for her to take care of getting the orders corrected.	D 344		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was not abated Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 9 of 9 sampled residents (#1, #2, #3, #6, #7, #8, #9, #11 and #13) including two blood pressure (BP) medications (#1); a BP medication (#2); two medications for BP and a medication for mood stabilizing (#3); an inhaler (#6); a medication for tremors (#7); an inhaler and a topical pain medication (#8); two inhalers (#9); a medication	{D 358}		

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{D 358}	Continued From page 170 for seizures and a medication for mood stabilizing (#11); and a BP medication (#13). The findings are: 1. Review of Resident #1's current FL-2 dated 11/05/24 revealed diagnoses included multiple falls, gait instability, diabetes mellitus type 2 with hyperglycemia, hypertension, and hyperlipidemia. Review of Resident #1's previous FL-2 dated 02/21/24 revealed diagnoses included cerebral vascular accident, coronary heart disease, and hyperlipidemia. Review of Resident #1's Emergency Medical Services (EMS) reports from 10/21/24 to 12/04/24 revealed: -Resident #1 was transported to the Emergency Department (ED) 9 times due to falls. -Resident #1 complained of dizziness with falls on 10/21/24, 10/26/24, 10/30/24, and 11/26/24. -Resident #1 experienced a low blood pressure (BP) of 78/49 on 10/26/24. -Resident #1 fell, hitting his head on 10/25/24 causing a laceration, an abrasion, and a hematoma to the back of his head. -Resident #1 fell, hitting his head on 10/26/24 causing a hematoma -Resident #1 fell, hitting his head on 10/30/24 causing a 1x1 cm abrasion on his scalp, 1cm abrasion above the right eyebrow with bruising around the right eye socket. -Resident #1 fell, hitting the back on his head on 10/31/24; he had multiple abrasions, skin tears, and bruises in various stages of healing over his body. -Resident #1 fell backward, hitting his head and did not remember the fall on 12/04/24.	{D 358}		

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{D 358}	Continued From page 171 Review of Resident #1's ED reports from 10/21/24 to 12/04/24 revealed: -On 10/21/24, Resident #1 fell while ambulating, staff reported Resident #1 was unconscious a few seconds, returned to facility and to follow-up with his primary care provider (PCP) and Neurologist. -On 10/24/24, Resident #1 fell with head injury, reported loss of consciousness less than 2 minutes, swelling noted in left elbow with no fracture noted, returned to facilty and to follow-up with PCP and Neurologist. -On 10/26/24, Resident #1 fell, hitting his head, causing a subarachnoid hemorrhage, transferred to a larger medical center, an discharged to the facility on 10/27/24. -On 10/30/24, Resident #1 fell, hitting his head causing a 1x1 cm full-thickness abrasion of the right scalp 1 cm above the eyebrow on the right with bruising around the right eye socket, returned to the facility. -On 12/04/24, Resident #1's fell, hitting the back of his head, causing a hematoma; discharged to the facility with instructions to follow up with his PCP in 2 days. Review of Resident #1's ED visit summary dated 10/30/24 revealed: -Resident #1 was seen in the ED related to a fall with head injury. -He was placed on observation for 24 hours, then admitted to the hospital on 10/31/24 for gait instability and multiple falls with injuries, likely secondary to orthostatic hypotension. Review of Resident #1's hospital discharge summary dated 11/05/24 revealed: -Resident #1 was admitted to the hospital for gait instability and multiple falls on 10/31/24. -Resident #1 was discharged to a skilled rehabilitation center for physical therapy and	{D 358}		

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{D 358}	Continued From page 172 occupational therapy on 11/05/24. -Resident #1's multiple falls with injuries likely secondary to orthostatic hypotension. -Resident #1's BP medications were discontinued. a. Review of Resident #1's discharge information from the rehabilitation center on 11/19/24 revealed: -There was a FL-2 and hospital discharge summary dated 11/05/24 that was sent to the rehabilitation center on 11/05/24 when Resident #1 was transferred from the hospital. -There was an order to discontinue amlodipine 10mg (used to treat BP) daily on the FL-2 on the discharge summary dated 11/05/24. -There were no other orders available for review Review of Resident #1's November 2024 electronic medication administration record (eMAR) from 11/20/24 to 11/30/24 revealed: -There was an entry for amlodipine 10mg daily with a scheduled administration time of 8:00am. -There was documentation amlodipine had been administered daily from 11/23/24 to 11/26/24. -There were exceptions documented from 11/20/24 to 11/21/24; the exception was withheld by doctors orders. -There was an exception documented on 11/22/24; the exception was resident refused. -There were exceptions documented from 11/27/24 to 11/30/24; the exception was resident was out of the facility. Review of Resident #1's December 2024 eMAR from 12/01/24 to 12/12/24 revealed: -There was an entry for amlodipine 10mg daily with a scheduled administration time of 8:00am. -There was documentation amlodipine had been administered daily from 12/03/24 to 12/06/24.	{D 358}		

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{D 358}	Continued From page 173 -There were exceptions documented on 12/01/24 and 12/02/24 and from 12/07/24 to 12/10/24; the exception was resident was out of facility. Review of Resident #1's blood pressure (BP) readings from November 2024 to December 2024 revealed: -There was documentation Resident #1's BP readings in November 2024 were from 89/53 to 155/105 -There was documentation Resident #1's BP reading in December 2024 were from 123/81 to 144/96. Observation of medication on hand for Resident #1 on 12/10/24 at 4:07pm revealed there was no amlodipine available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 12/13/24 at 2:36pm revealed: -The pharmacy had an order for amlodipine 10mg daily dated 10/15/24. -The medication was on cycle filled and a 30-day supply was dispensed on 10/01/24 and 11/01/24 to start on the cycle fill date of 10/06/24 and 11/06/24. b. Review of Resident #1's discharge information form the rehabilitation center on 11/19/24 revealed: -There was a FL-2 and hospital discharge summary dated 11/05/24 that was sent to the rehabilitation center on 11/05/24 when Resident #1 was transferred from the hospital. -There was an order to discontinue losartan potassium 100mg (used to treat BP) daily on the FL-2 and the discharge summary dated 11/05/24. -There were no other orders available for review.	{D 358}		

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{D 358}	Continued From page 174 Review of Resident #1's November 2024 eMAR 11/20/24 to 11/30/24 revealed: -There was an entry for losartan potassium 100mg daily with a scheduled administration time of 8:00am. -There was documentation losartan potassium had been administered daily from 11/20/24 to 11/25/24 at 8:00am. -There were exceptions documented from 11/26/24 to 11/30/24; the exception was resident out of facility. Review of Resident #1's December 2024 eMAR from 12/01/24 to 12/12/24 revealed: -There was an entry for losartan potassium 100mg daily with a scheduled administration time of 8:00am. -There was documentation losartan potassium had been administered daily from 12/03/24 to 12/06/24. -There were exceptions documented from 12/07/24 to 12/10/24; the exception was resident was out of the facility. -There was no documentation on 12/01/24 and 12/02/24; the eMAR was blank. Review of Resident #1's BP readings from November 2024 to December 2024 revealed: -There was documentation Resident #1's BP readings in November 2024 were from 89/53 to 155/105 -There was documentation Resident #1's BP reading in December 2024 were from 123/81 to 144/96. Observation of medication on hand for Resident #1 on 12/10/24 at 4:07pm revealed there was a bubble pack of 22 of 30 losartan potassium 100mg dispensed on 11/01/24 available for administration.	{D 358}		

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{D 358}	Continued From page 175 Telephone interview with a representative from the facility's contracted pharmacy on 12/13/24 at 2:36pm revealed: -The pharmacy had an order for losartan 100mg daily dated 08/13/24. -The medication was on cycle filled and a 30-day supply was dispensed on 10/01/24 and 11/01/24 to start on the cycle fill date of 10/06/24 and 11/06/24. Interview with a medication aide (MA) on 12/13/24 at 8:08am revealed: -Resident #1 was having multiple falls. -Resident #1 started falling frequently in October 2024. -Resident #1 was sent to the hospital frequently, but the hospital would send him back and would not make any changes to his medication. -Resident #1 complained of dizziness each time he got up to ambulate. -She told the Director that Resident #1 complained of dizziness every day. -She did not communicate with the primary care provider (PCP), the Director was the only one who communicated with the PCP. -Resident #1 continued to complain of dizziness and continued to fall after each hospitalization and ED visit. -Resident #1's BP was taken twice daily; there was only one time his BP was low. -On 11/25/24 at 8:00am Resident #1's BP was 89/53; she did not recall reporting Resident #1's low BP to the Director. -She did not review Resident #1's hospital discharge summary. -The Director was responsible for reviewing the hospital discharge summary and faxing new orders to the pharmacy. -There were no changes made to Resident #1's	{D 358}		

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eMAR when he returned to the facility on 11/19/24.
-She continued to administer the medications that were on Resident #1's eMAR, including the BP medications.
-She did not know Resident #1's BP medications had been discontinued when Resident #1 was in the hospital because Resident #1's BP was dropping.

Telephone interview with a representative from the facility's contracted pharmacy on 12/11/24 at 2:36pm revealed:
-The pharmacy did not know Resident #1 was in the hospital from 10/31/24 to 11/05/24, from 11/26/24 to 12/02/24 and did not know Resident #1 was currently in the hospital.
-The pharmacy did not receive a hospital discharge summary for Resident #1 dated 11/05/24.
-The facility should notify the pharmacy when a resident was out of the facility greater than 7 days.
-The pharmacy entered all medication orders into the computer.
-The pharmacy would not have any new orders for medications for Resident #1 since the discharge summaries were not received.

Telephone interview with a representative from the facility's contracted pharmacy on 12/12/24 at 4:29pm revealed:
-Orthostatic hypotension would happen when there was a sudden drop in a resident's BP when they stood up.
-When there was a sudden drop in BP, the resident could become dizzy.
-If Resident #1's BP medications were being administered even though they were discontinued because of orthostatic hypotension, Resident #1

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{D 358}	Continued From page 177 could become dizzy and fall. Interview with the Director on 12/11/24 at 11:22am revealed: -Resident #1 had multiple falls in the past 1 to 2 months with ED visits. -Resident #1 did not complain of dizziness to her. -The MA did not report a low BP reading to her. -She had witnessed several of Resident #1's falls. -One time, he got out of bed and walked to his bedroom door; he appeared unbalanced, confused and weak-eyed. -Another time she saw Resident #1 stumble in the hallway and she lowered him to the floor. -She reviewed the medications on the FL-2, but did not compare the FL-2 to the eMAR. -The pharmacy would enter the medications changes in the eMAR. -She thought she faxed Resident #1's FL-2 dated 11/05/24 to the pharmacy when Resident #1 returned to the facility from rehabilitation on 11/19/24. Interview with the Administrator on 12/17/24 at 2:53pm revealed: -He did not know Resident #1 was falling. -He did not know what orthostatic hypotension was. -He did not know Resident #1's BP medications were continually being administered after they had been discontinued in the hospital. -He was concerned about the safety of Resident #1 because he continued being administered BP medication after it was discontinued, and continued to complain of dizziness and was having falls. -The facility staff did not do what should have been done to take care of Resident #1's well-being. -He expected the Director to fax all discharge	{D 358}		

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{D 358}	Continued From page 178 summaries and FL-2 to the pharmacy for review, so medication changes could be added to the eMAR. Attempted telephone interviews with Resident #1's PCP on 12/13/24 at 10:09am and on 12/16/24 at 9:00am were unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #1 was hospitalized and was unable to be interviewed. Refer to the interview with a MA on 12/10/24 at 1:14pm. Refer to the interview with the Director on 12/12/24 at 3:15pm. Refer to the interview with the Director on 12/16/24 at 2:45pm. Refer to the telephone interview with the Administrator on 12/17/24 at 2:42pm. 2. Review of Resident #11's current FL-2 dated 11/26/24 revealed: -Diagnoses included acute respiratory failure requiring intubation, breakthrough seizure, generalized tonic-clonic seizures, prolactinoma, status epilepticus, history of traumatic brain injury, cognitive developmental delay, chronic static encephalopathy, and intellectual disability with epilepsy. -Resident #11 was admitted to the hospital on 11/19/24. Review of Resident #11's Emergency Medical Services (EMS) reports from 11/09/24 to 11/17/24 revealed: -Resident #11 was transported to the emergency	{D 358}		

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department (ED) on 11/09/24 after experiencing multiple seizures, falling from a chair, and hitting his head on the floor.
-The staff reported on 11/12/24, Resident #11 had a seizure, fell, hitting his head against the wall.
-Resident #11 was transported to the ED on 11/16/24 with altered mental status and slurred speech.

Review of Resident #11's ED visit reports from 11/09/24 to 11/17/24 revealed:
-On 11/09/24, Resident #11 was discharged to the facility with instructions to follow-up with his primary care provider (PCP); there were no medication changes.
-On 11/12/24, Resident #11 was discharged to the facility with instructions to follow-up with his PCP and a Neurologist.
-On 11/17/24, Resident #11 presented with intermittent confusion, had frequent focal seizures lasting 30 seconds to 2 minutes involving tonic movement of the right hand, later deviation of the eyes to the right, and right lateral rotation of the head, Keppra was administered intravenously, and once stable, Resident #11 was transferred to a larger medical facility to be seen by a Neurologist.

Review of Resident #11's former PCP's after visit summary dated 11/12/24 revealed:
-The visit was by Teletriage.
-He was seen in the ED on 11/09/24 for seizure activity.
-He reported having another witnessed seizure yesterday on 11/11/24.
-He stated his balance seemed to be getting worse.
-He was having increased breakthrough seizures.
-His Keppra (used to control seizures) was

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increased from 1000mg twice daily to 1500mg twice daily.
-He was to continue Zonisamide 200mg (used to treat seizures) nightly.

Review of Resident #11's hospital discharge summary dated 11/26/24 revealed:
-Resident #11 was admitted to the hospital on 11/19/24 for seizure management.
-Resident #11 had 8 seizures while in route from the local ED.
-In March 2024, Resident #11 was weaned off Depakote (used to treat seizure disorders) and started on Zonisamide and was to continue Keppra (used to treat partial onset seizures with epilepsy).
-Resident #11 was started on Keppra 1500mg intravenously in the ED.
-Resident #11 was placed on airway protection and admitted to the intensive care unit (ICU) on 11/19/24.
-Once Resident #11's seizures were controlled, he was extubated on 11/22/24.
-Resident #11 was discharged to the facility on 11/26/24.

a. Review of Resident #11's hospital discharge summary dated 11/26/24 revealed there was an order for divalproex 250mg (used to treat seizures) three tablets (750mg) every 12 hours.

Review of Resident #11's signed physician order dated 11/29/24 revealed:
-There was an order to discontinue divalproex 250mg 3 tablets every 12 hours.
-There was an order for divalproex 250mg take 3 tablets (750mg) every night.

Review of Resident #11's November 2024 electronic medication administration record

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{D 358}	Continued From page 181 (eMAR) from 11/26/24 to 11/30/24 revealed: -There was an entry for divalproex 250mg take 3 tablets every 12 hours with a scheduled administration time of 8:00am and 8:00pm. -There was documentation divalproex was administered on 11/26/24 at 8:00pm and on 11/27/24 and 11/28/24 at 8:00am and 8:00pm. -There was an exception documented on 11/29/24 at 8:00am; the exception was resident refused. -There was a second entry dated 11/29/24 for divalproex 250mg take 3 tablets every night with a scheduled time of 12:00am. -There was no documentation divalproex was administered on 11/29/24 and 11/30/24 at 12:00am; the eMAR was blank. Review of Resident #11's December 2024 eMAR from 12/01/24 to 12/13/24 revealed: -There was an entry for divalproex 250mg take 3 tablets every night with a scheduled time of 12:00am. -There was no documentation divalproex was administered from 12/01/24 to 12/13/24 at 12:00am; the eMAR was blank. Observation of medication on hand for Resident #11 on 12/13/24 at 2:53pm revealed: -There were three bubble packs of 90 divalproex 250mg on the medication cart and available for administration dispensed on 12/05/24. -The prescription label read take 3 tablets every night. Telephone interview with a representative from the facility's contracted pharmacy on 12/13/24 at 2:09pm revealed: -Resident #11 had an order dated 11/26/24 for divalproex 250mg three tablets twice daily that was received on 11/26/24 from a physician at a	{D 358}		

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{D 358}	Continued From page 182 hospital. -The pharmacy dispensed 66 tablets on 11/26/24, which was an 11-day supply, that would last until the new cycle started on 12/06/24. -The pharmacy received an order on 11/29/24 from Resident #11's previous PCP to discontinue divalproex 250mg three tablets twice a day and to administer divalproex 250mg 3 tablets at night. -The pharmacy dispensed 90 tablets of divalproex 250mg on 12/05/24. Interview with Resident #11 on 12/16/24 at 9:22am revealed: -He had been in the hospital for 1 to 2 weeks; he could not remember the dates. -His seizure "had gotten really bad." -The staff would tell him when he had a seizure because he could not remember having them. -He took medication for his seizures, but he did not know the names of the medications. -He had been to the ED many times for his seizures. Observation of Resident #11's eMAR on the computer on 12/13/24 at 3:01pm revealed: -There was an entry on the eMAR for divalproex 250mg 3 tablets every night. -The word "ERROR" appeared on the eMAR and was highlighted in red. -The words "NO SCHEDULE" was documented on the eMAR. -The "ERROR" message read "administration schedule was invalid and could not be administered." Interview with a medication aide (MA) on 12/13/24 at 3:01pm revealed: -She could not click on the tab and open the screen to see the medication divalproex to administer the medication.	{D 358}		

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MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 183 -She did not know the last time Resident #11 was administered divalproex 250mg 3 tablets at bedtime. -She notified the Director of the "ERROR" message, but she could not recall the day of the notification. Interview with the Director on 12/13/24 at 3:04pm revealed: -She did not know there was an "ERROR" message on the eMAR for Resident #11's divalproex. -She had not been notified there was an "ERROR" message on the eMAR and that Resident #11 was not administered his divalproex. -Resident #11 returned from the hospital on 11/26/24. -Resident #11 was admitted to the hospital because he was having seizures. Interview with the Director on 12/13/24 at 3:11pm revealed: -She had corrected the "ERROR" on Resident #11's eMAR. -There was not a correct time for administration entered on Resident #11's eMAR. -The administration time was 12:00am and she changed it to 8:00am. -The "ERROR" was corrected by changing the time and the divalproex could be administered as ordered. Interview with the Administrator on 12/17/24 at 2:42pm revealed: -The Director should have been notified by the MA if there was a problem with the eMAR and the MA was not able to administer a medication as ordered. -The Director would have seen the "ERROR" on	{D 358}		

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{D 358}	Continued From page 184	{D 358}		

the eMAR if she compared each medication that was delivered by the pharmacy against the eMAR for accuracy.
-He expected all medications to be administered as ordered and if there was a problem with the computer, the Director should call the pharmacy.
-Resident #11 was hospitalized last month for seizure and he could have another onset of seizures because his medication was not administered as ordered.

Attempted telephone interviews with Resident #11's PCP on 12/13/24 at 10:09am and on 12/16/24 at 9:00am were unsuccessful.

b. Review of Resident #11's hospital discharge summary dated 11/26/24 revealed there was an order for olanzapine 5mg (used to manage mood and behaviors) one tablet twice daily.

Review of Resident #11's November 2024 eMAR from 11/27/24 to 11/30/24 revealed:
-There was an entry for olanzapine 5mg ½ tablet twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation olanzapine ½ tablet was administered twice daily from 11/27/24 to 11/30/24.
-There was no entry for olanzapine 5mg one tablet twice daily.
-There was no documentation olanzapine 5mg was administered twice daily.

Review of Resident #11's December 2024 eMAR from 12/01/24 and 12/12/24 revealed:
-There was an entry for olanzapine 5mg ½ tablet twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation olanzapine ½ tablet was administered twice daily from 12/01/24 to

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{D 358}	Continued From page 185 12/12/24. -There was no entry for olanzapine 5mg one tablet twice daily. -There was no documentation olanzapine 5mg was administered twice daily. Observation of medication on hand for Resident #11 on 12/16/24 at 2:30pm revealed: -There were two bubble packs of olanzapine 5mg tablets on the medication cart and available for administration with 60 1/2 tablets dispensed on 12/01/24. -There were 21 1/2 tablets remaining in each bubble pack. -The prescription label read take 1/2 tablet twice daily. Interview with Resident #11 on 12/16/24 at 9:22am revealed: -There were times he did not want to be around people; he wanted to be left alone. -Sometimes the people here would not leave him alone; he did not want to talk to them. Observation of the backyard of the facility on 12/16/24 at 4:25pm to 4:30pm revealed: -Resident #11 was walking in the backyard with his walker, toward the woods; two facility staff personnel walked after him. -The two facility staff reached Resident #11 when he approached the edge of the woods. -The two facility staff were conversing with Resident #11. -Resident #11 sat down on a rock at the edge of the woods. -After a few minutes, Resident #11 walked back to the facility with the two staff. Interview with Resident #11 on 12/16/24 at 4:36pm revealed:	{D 358}		

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{D 358}	Continued From page 186 -He went for a walk because he wanted to. -Everything was wrong, and it upset him. -He did not know what happened. Telephone interview with a representative from the facility's contracted pharmacy on 12/13/24 at 2:09pm revealed: -The pharmacy had an order for Olanzapine 5mg take ½ tablet twice daily. -The pharmacy dispensed 30-1/2 tablets on 12/01/24 to start the cycle fill dated 12/06/24. -The pharmacy did not have an order to change olanzapine to 5mg 1 tablet twice daily. -The pharmacy did not receive a hospital discharge summary for Resident #11 for a hospital discharge dated 11/26/24. -If the pharmacy had received the hospital discharge summary dated 11/26/24 for Resident #11, a pharmacist would have reviewed the hospital discharge summary for changes with medication orders. Interview with the Supervisor on 12/16/24 at 9:50pm revealed: -The Director was responsible for reviewing the hospital discharge summary and faxing it to the pharmacy. -If a resident returned from the hospital after the Director had left for the day, the hospital discharge summary would be slipped under her door. -She did not know Resident #11's olanzapine dosage had been changed when he returned from the hospital and that it was not changed on the eMAR. Interview with the Activity Director on 12/16/24 at 4:31pm revealed: -A group of residents were playing cards and Resident #11 was losing.	{D 358}		

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{D 358}	Continued From page 187 -Resident #11 would act out when he did not get his way or if he did not win. -Resident #11 walked out of the dining room when he got mad. Interview with the Director on 12/16/24 at 4:45pm revealed: -She received Resident #11's FL-2 and hospital discharge summary when he returned from the hospital. -She reviewed Resident #11's hospital discharge summary for medication changes. -The hospital would send the medication orders to the pharmacy. -The hospital called and asked what pharmacy the facility used so they could send medication changes to the pharmacy. -She did not call the pharmacy to see if they received Resident #11's hospital discharge summary. -She did not know Resident #11's olanzapine dosage was increased when he was discharged from the hospital. -When she reviewed the hospital discharge summary, she noted olanzapine was still an active medication but did not notice the change in dosage. -Resident #11 would act out at times; he liked to be alone most of the time. -He did not like talking to people. -He became agitated and anxious easily. -She did not know that olanzapine was used for anxiety and agitation. Interview with the Administrator on 12/17/24 at 2:42pm revealed: -The Director was responsible for reviewing the hospital discharge summary and faxing it to the pharmacy for review. -The pharmacy would enter all new orders in the	{D 358}		

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{D 358}	Continued From page 188 eMAR and dispensed the medication to be administered. -The medication was needed to help control the behavior of Resident #11, who was known to the staff for his behaviors. -He expected the medication to be administered as ordered. Attempted telephone interviews with Resident #11's mental health provider (MHP) on 12/12/24 at 8:15am, on 12/13/24 at 11:48am, and on 12/16/24 at 9:02am were unsuccessful. Refer to the interview with a MA on 12/10/24 at 1:14pm. Refer to the interview with the Director on 12/12/24 at 3:15pm. Refer to the interview with the Director on 12/16/24 at 2:45pm. Refer to the telephone interview with the Administrator on 12/17/24 at 2:42pm. 3. Review of Resident #7's current FL-2 dated 07/27/24 revealed diagnosis included schizoaffective disorder. Review of Resident #7's signed physician's order dated 07/27/24 revealed there was an order for benztropine 1mg (used to treat tremors) twice daily. Review of Resident #7's signed physician's order dated 11/08/24 revealed: -There was an order to discontinue benztropine 1mg. -There was an order for benztropine 1mg take ½ tablet twice daily for 1 week then discontinue.	{D 358}		

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{D 358}	Continued From page 189 Review of Resident #7's November electronic medication administration record (eMAR) revealed: -There was an entry for benztropine 1mg take 1 tablet twice daily with a scheduled administration time of 9:00am and 9:00pm, -There was documentation benztropine was administered twice daily from 11/01/24 to 11/07/24 and on 11/08/24 at 9:00am. -There was an entry for benztropine 1mg take ½ tablet twice daily for 1 week then discontinue. -There was documentation benztropine ½ tablet was administered on 11/11/24 and 11/12/24 at 9:00am and 9:00pm; and 11/08/24, 11/14/24 and 11/15/24 at 9:00pm. -There were exceptions documented on 11/09/24, 11/10/24 and 11/13/24 at 9:00am and 9:00pm; and 11/14/24 and 11/15/24 at 9:00am; the exception was resident was physically unable to take. Observation of Resident #7's medication on hand on 12/10/24 at 8:42am revealed: -There was an empty bubble pack of benztropine 1mg tablet on the medication cart. -The dispensed date was 11/01/24 for 60 tablets. -The directions on the prescription label read take one twice daily. Telephone interview with a representative from the facility's contracted pharmacy on 12/11/24 at 2:04pm revealed Resident #7 had an order to discontinue benztropine 1mg twice daily and to start benztropine 1mg take ½ tablet twice daily on 11/08/24 for one week and then discontinue the medication. Telephone interview with the same representative from the facility's contracted pharmacy on	{D 358}		

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{D 358}	Continued From page 190 12/13/24 at 2:09pm revealed: -The pharmacy did not dispense ½ tablets of benztropine when the order dated 11/08/24 was received. -The facility had received a month's supply of 60 tablets of benztropine 1mg on 11/01/24 to start their monthly cycle on 11/06/24. -The facility had more than enough benztropine available to administer ½ tablet twice daily for 7 days. -If the facility staff had administered the benztropine 1mg twice daily until 11/08/24 and then ½ tablet for one week and stopped the medication, the facility should have 42 tablets remaining. -When the MA administered benztropine 1mg ½ tablet, the MA should have popped a whole tablet from the bubble pack, broke the tablet in half, administered ½ of the tablet and disposed of ½ of the tablet. Interview with a medication aide (MA) on 12/10/24 at 8:08am revealed: -Resident #7's primary care provider (PCP) discontinued the benztropine in November 2024. -The bubble pack was empty because Resident #7 had taken all the benztropine. Interview with the same MA on 12/12/24 at 2:41pm revealed: -She did not recall having any ½ tablets of benztropine to administer to Resident #7. -She did not recall if she had broken a whole tablet in half to administer a ½ tablet to Resident #7. -She did not know why there were no benztropine tablets remaining in the bubble pack. -She administered what the pharmacy dispensed. Interview with a second MA on 12/13/24 at	{D 358}		

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{D 358}	Continued From page 191 8:08am revealed: -She thought there were ½ tablets of benztropine available for Resident #7, but she was not sure. -She did not know why the bubble pack of benztropine 1mg tablets was empty when there should have been tablets left after the medication was discontinued. Interview with the Director on 12/16/24 at 4:45pm revealed: -She did not know the pharmacy did not dispense 1/2 tablets of benztropine 1mg to be administered. -She did not know the pharmacy expected the MAs to break a whole tablet in half, administer half and dispose of half the tablet. -She did not know why there were no benztropine tablets left, because there should have been. -She did not know what happened to the benztropine tablets that should remain. -She expected medication to be administered as ordered. Telephone interview with the Administrator on 12/17/24 at 2:42pm revealed: -Resident #7 could have had some problems, he did not know what kind of problems, from taking too much of the medication and not tapering the medication as ordered. -He expected the MAs to administer medications as ordered. Attempted telephone interviews with Resident #7's mental health provider (MHP) on 12/12/24 at 8:15am, on 12/13/24 at 11:48am, and on 12/16/24 at 9:02am were unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.	{D 358}		

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{D 358}	Continued From page 192 Refer to the interview with a MA on 12/10/24 at 1:14pm. Refer to the interview with the Director on 12/12/24 at 3:15pm. Refer to the interview with the Director on 12/16/24 at 2:45pm. Refer to the telephone interview with the Administrator on 12/17/24 at 2:42pm. 4. Review of Resident #8's current FL-2 dated 11/08/23 revealed diagnoses included metabolic encephalopathy, asthma, dementia, muscle weakness and constipation. a. Review of Resident #8's signed physician orders dated 11/08/23 revealed there was an order for wixela 250-50 inhaler (used to treat shortness of breathe and wheezing associated with asthma) inhale 1 puff into lungs every 12 hours. Review of Resident #8's October 2024 medication administration record (MAR) from 10/10/24 to 10/31/24 revealed. -There was an entry for wixela 250-50 inhaler inhale 1 puff into lungs every 12 hours with a scheduled administration time of 9:00am and 9:00pm. -There was documentation wixela inhaler was administered 21 times out of 62 opportunities. -There was no documentation wixela inhaler was administered 41 times our of 62 opportunities; there were no exceptions documented. Review of Resident #8's November 2024 electronic medication administration record	{D 358}		

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{D 358}	Continued From page 193 (eMAR) revealed: -There was an entry for wixela 250-50 inhaler inhale 1 puff into lungs every 12 hours with a scheduled administration time of 9:00am and 9:00pm. -There was documentation wixela inhaler was administered 17 times out of 60 opportunities. -There was no documentation wixela inhaler was administered 43 times out of 60 opportunities; the exceptions were the resident refused, and the resident was physically unable to take. Review of Resident #8's December eMAR from 12/01/24 to 12/10/24 revealed: -There was an entry for wixela 250-50 inhaler inhale 1 puff into lungs every 12 hours with a scheduled administration time of 9:00am and 9:00pm. -There was documentation wixela inhaler was not administered twice daily from 12/01/24 to 12/12/24. -There were exceptions documented from 12/01/24 to 12/12/24 twice daily; the exceptions were resident refused, and the resident was physically unable to take. Observation of medication on hand for Resident #8 on 12/10/24 at 8:11am revealed there was no wixela 250-50 inhaler available for administration on the medication cart. Telephone interview with a representative from the facility's contracted pharmacy on 12/11/24 at 2:04pm revealed: -Resident #8 had an order for wixela 250-50 inhaler inhale 1 puff into lungs every 12 hours dated 08/13/24. -The Director telephoned the pharmacy on 11/27/24 and 12/02/24 to order the wixela inhaler. -The pharmacy sent a non-coverage notification	{D 358}		

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{D 358}	Continued From page 194 to the facility and to the primary care provider (PCP) on 11/27/24 because Resident #8's insurance would not cover the wixela inhaler. -The pharmacy sent a second non-coverage notification to the facility and to the PCP on 12/02/24. -The pharmacy had not heard from the facility or the PCP regarding the non-coverage of the wixela inhaler as of 12/10/24. -The pharmacy had not dispensed a wixela 250-50 inhaler for Resident #8 since receiving the order dated 08/13/24. Interview with Resident #8 on 12/16/24 at 12:02pm revealed: -She did not use an inhaler. -She did not have problems breathing. Interview with a medication aide (MA) on 12/10/24 at 1:14pm revealed: -Resident #8's wixela was not available to administer. -She had pulled the reorder sticker from the prescription label and gave the sticker to the Director to reorder; she did not remember when. Interview with the same MA on 12/12/24 at 2:41pm revealed: -She did not remember the last time she administered wixela inhaler to Resident #8. -There was no response given by the MA when she was asked if she had ever administered wixela inhaler to Resident #8. Interview with a second MA on 12/13/24 at 8:08am revealed: -She did not recall seeing an inhaler for Resident #8 on the medication cart. -She did not recall administering an inhaler to Resident #8.	{D 358}		

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{D 358}	Continued From page 195 -Resident #8 did not complain about shortness of breath. -She had not told the Director that the inhaler was not available. Telephone interview with the previous PCP on 12/11/24 at 5:21pm revealed: -Resident #8 had an order for wixela 250-50 inhaler 1 puff every 12 hours. -Resident #8 had a history of asthma and the medication would help control symptoms of asthma. -Resident #8 could have an exacerbation of asthma if she did not receive the medication as ordered. -She did not know Resident #8's insurance would not pay for this medication and that Resident #8 had not received the inhaler since August 2024. -Resident #8 did not have any documented issues with asthma. Interview with the Director on 12/16/24 at 4:45pm revealed: -She did not recall receiving a non-coverage form from the pharmacy. -She did not know the pharmacy had not dispensed wixela inhaler since the facility switched over to the current pharmacy. -She knew inhalers were not on cycle fill and had to be reordered monthly. -She notified the pharmacy on 11/27/24 and 12/02/24 that Resident #8 needed an inhaler. -She expected the MAs to let her know when medication needed to be reordered, and to let her know before the medication ran out. Telephone interview with the Administrator on 12/17/24 at 2:42pm revealed: -The MAs should have notified the Director that the inhaler was not available.	{D 358}		

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{D 358}	Continued From page 196 -The Director should have notified the pharmacy as to why the medication was not available. -Once the Director knew Resident #8's insurance would not cover the inhaler, the Director should have notified the PCP. -Resident #8 could have breathing problems from not receiving the inhaler. Refer to the interview with a MA on 12/10/24 at 1:14pm. Refer to the interview with the Director on 12/12/24 at 3:15pm. Refer to the interview with the Director on 12/16/24 at 2:45pm. Refer to the telephone interview with the Administrator on 12/17/24 at 2:42pm. b. Review of Resident #8's signed physician's orders dated 07/21/24 revealed there was an order for diclofenac sodium 1% gel (used to treat pain) apply 4gms three times daily to knees. Review of Resident #8's October 2024 MAR from 10/10/24 to 10/31/24 revealed. -There was an entry for diclofenac sodium gel 1% apply 4 grams three times daily to knees with a scheduled application time of 9:00am, 3:00pm and 9:00pm. -There was documentation diclofenac sodium gel was applied from 10/10/24 to 10/30/24 at 9:00pm. -There was no documentation diclofenac sodium gel was applied from 10/10/24 to 10/31/24 at 9:00am and 3:00pm; and on 10/31/24 at 9:00pm; the MAR was blank. -There were no exceptions documented from 10/10/24 to 10/30/24 at 9:00pm.	{D 358}		

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{D 358}	Continued From page 197 Review of Resident #8's November 2024 eMAR revealed: -There was an entry for diclofenac sodium gel 1% apply 4 grams three times daily to knees with a scheduled application time of 9:00am, 3:00pm and 9:00pm. -There was documentation diclofenac sodium gel was applied 8 times out of 90 opportunities. -There was no documented diclofenac sodium gel was applied 82 times out of 90 opportunities; the exceptions were the resident refused, and the resident was physically unable to take. Review of Resident #8's December 2024 eMAR from 12/01/24 to 12/10/24 revealed: -There was an entry for diclofenac sodium gel 1% apply 4 grams three times daily to knees with a scheduled application time of 9:00am, 3:00pm and 9:00pm. -There was documentation diclofenac sodium gel was not applied three times daily from 12/01/24 to 12/12/24. -There were exceptions documented from 12/01/24 to 12/12/24 three times daily; the exceptions were the resident refused, and the resident was physically unable to take. Observation of medication on hand for Resident #8 on 12/10/24 at 8:11am revealed there was no diclofenac sodium gel 1% available for application on the medication cart. Telephone interview with a representative from the facility's contracted pharmacy on 12/10/24 at 3:30pm revealed: -Resident #8 had an order for diclofenac sodium get 1% apply 4 grams to knees three times daily dated 08/13/24. -Diclofenac sodium gel had been dispensed once since 08/13/24.	{D 358}		

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{D 358}	Continued From page 198 -The pharmacy dispensed one tube of diclofenac sodium gel 100gms on 11/14/24. -One tube of diclofenac gel would last 25 days when applying 4 grams a day. -This medication was not on cycle fill; the facility staff would have to call the pharmacy to request a refill. -Diclofenac sodium gel was a topical pain medication to help with arthritis pain. Interview with Resident #8 on 12/16/24 at 12:02pm revealed: -She did not get medication applied to her legs. -Her legs hurt sometimes. Telephone interview with Resident #8's family member on 12/16/24 at 10:14am revealed: -Resident #8 had arthritis in her knees. -She thought Resident #8 received a cream to her knees for arthritic pain. Interview with a MA on 12/10/24 at 1:14pm revealed: -Resident #8's diclofenac sodium gel was not available to apply. -She had pulled the reorder sticker from the prescription label and gave the sticker to the Director to reorder; she did not remember when. Interview with a second MA on 12/13/24 at 8:08am revealed: -She did not recall seeing diclofenac sodium gel for Resident #8 on the medication cart. -She did not recall applying diclofenac gel to Resident #8's knees. -Resident #8 complained about her legs hurting about twice a week. -She had not told the Director that the diclofenac sodium gel was not available.	{D 358}		

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{D 358}	Continued From page 199 Telephone interview with the previous PCP on 12/11/24 at 5:21pm revealed: -Resident #8 had an order for diclofenac sodium gel 1% apply 4gms to knees three times daily. -Diclofenac sodium gel was used for arthritic pain. -Resident #8 could have an increase in pain in her knees if the diclofenac sodium gel was not applied as ordered. Interview with the Director on 12/16/24 at 4:45pm revealed: -She did not know the pharmacy had dispensed diclofenac sodium gel only once since the facility switched over to the current pharmacy. -She knew diclofenac sodium gel was not on cycle fill and had to be reordered monthly. -She expected the MA to let her know when medication needed to be reordered, and to let her know before the medication ran out. Telephone interview with the Administrator on 12/17/24 at 2:42pm revealed: -The MAs should have notified the Director that diclofenac sodium gel was not on the medication cart so the Director could reorder the medication. -He expected the MAs to administer the medications as ordered. -Resident #8 could have increased pain in her knees. Refer to the interview with a MA on 12/10/24 at 1:14pm. Refer to the interview with the Director on 12/12/24 at 3:15pm. Refer to the interview with the Director on 12/16/24 at 2:45pm.	{D 358}		

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{D 358}	Continued From page 200 Refer to the telephone interview with the Administrator on 12/17/24 at 2:42pm. 5. Review of Resident #9's current FL-2 dated 3/18/24 revealed diagnosis included chronic obstructive pulmonary disease (COPD). a. Review of Resident #9's signed physician orders dated 03/18/24 revealed there was an order for Combivent Respimat inhaler (used to treat shortness of breath) inhale 1 puff four times daily. Review of Resident #9's October 2024 medication administration record (MAR) from 10/10/24 to 10/31/24 revealed. -There was an entry for Combivent Respimat 20-100mcg inhale 1 puff four times daily with a scheduled administration time of 9:00am, 3:00pm, 5:00pm and 9:00pm. -There was documentation Combivent Respimat inhaler was administered 86 times out of 124 opportunities. -There was no documentation Combivent Respimat inhaler was administered 38 times out of 124 opportunities; the MAR was blank. Review of Resident #9's November electronic medication administration record (eMAR) revealed: -There was an entry for Combivent Respimat 20-100mcg inhale 1 puff four times daily with a scheduled administration time 9:00am, 3:00pm, 5:00pm and 9:00pm. -There was documentation Combivent Respimat inhaler was administered 109 times out of 124 opportunities. -There was no documentation Combivent Respimat inhaler was administered 15 times out of 124 opportunities; the exception was resident	{D 358}		

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{D 358}	Continued From page 201 was out of the facility. Review of Resident #9's December eMAR from 12/01/24 to 12/10/24 revealed: -There was an entry for Combivent Respimat 20-100mcg inhale 1 puff four times daily with a scheduled administration time 9:00am, 3:00pm, 5:00pm and 9:00pm. -There was documentation Combivent Respimat inhaler was administered 36 times out of 36 opportunities. Observation of medication on hand for Resident #9 on 12/10/24 at 8:57am revealed there was one Combivent Respimat 20-100mcg inhaler available for administration dispensed on 12/04/24 with 1 of 120 inhalations remaining. Telephone interview with a representative from the facility's contracted pharmacy on 12/11/24 at 2:04pm revealed: -Resident #9 had an order for Combivent Respimat 20-100mcg inhale 1 puff four times daily. -The pharmacy dispensed one Combivent Respimat inhaler on 08/30/24, 10/22/24 and 12/04/24. -The Combivent Respimat inhaler had 120 inhalations available for administration which would last 30 days. -Inhalers were not on cycle fill; the facility would have to notify the pharmacy when a refill was needed. Telephone interview with the previous primary care provider (PCP) on 12/11/24 at 5:21pm revealed: -Resident #9 had an order for Combivent Respimat 20-100mcg inhale 1 puff four times daily.	{D 358}		

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{D 358}	Continued From page 202 -Combivent was used to control symptoms of COPD. -Resident #9 could have shortness of breath and exacerbation of COPD if the medication was not administered as ordered. -She did not know if Resident #9 had any recent issues with COPD. b. Review of Resident #9's signed physician's orders dated 03/18/24 revealed there was an order for Symbicort 160-4.5mcg inhaler (used to treat asthma and COPD) inhale 2 puffs twice daily. Review of Resident #9's October 2024 MAR from 10/10/24 to 10/31/24 revealed. -There was an entry for Symbicort 160-4.5mcg inhaler inhale 2 puffs twice daily with a scheduled administration time of 9:00am and 9:00pm. -There was documentation Symbicort inhaler was administered 61 times out of 62 opportunities. -There was no documentation Symbicort inhaler was administered on 10/31/24 at 9:00pm; the MAR was blank. Review of Resident #9's November eMAR revealed: -There was an entry for Symbicort 160-4.5mcg inhaler inhale 2 puffs twice daily with a scheduled administration time of 9:00am and 9:00pm. -There was documentation Symbicort inhaler was administered 58 times out of 60 opportunities. -There was no documentated Symbicort inhaler was administered on 11/27/24 at 9:00pm to 11/28/24 at 9:00pm; the exception was resident was out of the facility. Review of Resident #9's December eMAR from 12/01/24 to 12/10/24 revealed: -There was an entry for Symbicort 160-4.5mcg	{D 358}		

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{D 358}	Continued From page 203 inhaler inhale 2 puffs twice daily with a scheduled administration time of 9:00am and 9:00pm. There was documentation Symbicort inhaler was administered 19 times out of 19 opportunities. Observation of medication on hand for Resident #9 on 12/10/24 at 8:57am revealed there was one Symbicort 160/4.5mcg inhaler available for administration dispensed on 09/17/24 with 18 of 120 inhalations remaining. Telephone interview with a representative from the facility's contracted pharmacy on 12/11/24 at 2:04pm revealed: -Resident #9 had an order for Symbicort 160-4.5mcg inhaler inhale 2 puffs twice daily. -The pharmacy dispensed one Symbicort inhaler on 09/17/24 and 12/07/24. -The Symbicort inhaler had 120 inhalations available for administration which would last 30 days. -Inhalers were not on cycle fill; the facility would have to notify the pharmacy when a refill was needed. Telephone interview with the previous PCP on 12/11/24 at 5:21pm revealed: -Resident #9 had an order for Symbicort 160-4.5mcg inhaler inhale 2 puffs twice daily. -Symbicort was used to control symptoms of COPD. -Resident #9 could have shortness of breath and exacerbation of COPD if the medication was not administered as ordered. -She did not know if Resident #9 had any recent issues with COPD. Interview with Resident #9 on 12/12/24 at 11:30am revealed: -He had COPD and used inhalers.	{D 358}		

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{D 358}	Continued From page 204 -He used inhalers 3 to 4 times a day. -He always took his inhalers because he did not want problems breathing. -He did not refuse his inhalers. Interview with a medication aide (MA) on 12/12/24 at 2:41pm revealed: -Resident #9 would refuse the inhalers if he was mad. -Resident #9 would take his medications most of the time; she could not say how many times a week or month Resident #9 refused his medications. -She could not recall if Resident #9's inhalers were not in the facility and available to administer. -She did not know why Resident #9's inhalers were not dispensed every 30 days. Interview with a second MA on 12/13/24 at 8:08am revealed: -Resident #9's inhalers were always available to administer. -Resident #9 did not refuse his inhalers. -Resident #9 had not complained of shortness of breath or difficulty breathing. -She did not know why Resident #9's inhalers had not been sent from the pharmacy each month. Interview with the Director on 12/16/24 at 4:45pm revealed: -Resident #9 did not refuse his medications. -She did not know Resident #9's inhalers were not dispensed timely. -She expected the MA to pull the sticker for reordering medications a week before the medication ran out. Telephone interview with the Administrator on 12/17/24 at 2:42pm revealed: -He expected the MAs to pull the stickers from	{D 358}		

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{D 358}	Continued From page 205	{D 358}		

the prescription labels and give the stickers to the Director so the medications could be ordered timely.
-He expected the MA to administer the medications as ordered.
-If the inhalers were not dispensed monthly, then the resident could have breathing problems.

Refer to the interview with a MA on 12/10/24 at 1:14pm.

Refer to the interview with the Director on 12/12/24 at 3:15pm.

Refer to the interview with the Director on 12/16/24 at 2:45pm.

Refer to the telephone interview with the Administrator on 12/17/24 at 2:42pm.

6. Review of Resident #3's most recent FL-2 dated 11/06/23 revealed diagnoses included schizophrenia, mild retardation, diabetes mellitus type 2, and hypertension.

a. Review of Resident #3's most recent FL-2 dated 11/06/23 revealed there was an order for amlodipine besylate (used to treat high blood pressure) 5mg once daily.

Review of Resident #3's physician's order dated 08/28/24 revealed:
-There was an order for amlodipine besylate 5mg once daily.
-The order was for a thirty-day supply with zero refills; do not refill was check on the order.

Review of Resident #3's medication administration record (MAR) for October 2024 revealed:

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{D 358}	Continued From page 206 -There was an entry for amlodipine besylate 5mg once daily administered scheduled at 8:00am. -There was documentation amlodipine besylate was administered 31 of 31 opportunities from 10/01/24 to 10/31/24. Review of Resident #3's electronic medication administration record (eMAR) for November 2024 revealed: -There was an entry for amlodipine besylate 5mg once daily administered scheduled at 8:00am. -There was documentation amlodipine besylate was administered 30 of 30 opportunities from 11/01/24 to 11/01/24. Review of Resident #3's eMAR for December 2024 from 12/01/24 to 12/13/24 revealed: -There was an entry for amlodipine besylate 5mg once daily administered scheduled at 8:00am. -There was documentation amlodipine besylate was administered 8 of 13 opportunities from 12/01/24 to 12/13/24. -Amlodipine besylate was documented 5 times as physically unable to take on 12/07/24, 12/09/24, 12/11/24, 12/12/24, and 12/13/24. -Amlodipine was documented in the notes on the eMAR as waiting for it to come in from the pharmacy on 12/07/24. Observations of Resident #3's medication on hand on 12/10/24 at 2:08pm and 12/12/24 at 10:56am revealed there was no amlodipine besylate available for administration. Observation of Resident #3 on 12/10/24 at 3:55pm revealed: -A medication aide (MA) took his blood pressure in his room with a battery-operated blood pressure cuff. -The results of his blood pressure check were	{D 358}		

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{D 358}	Continued From page 207 systolic reading was 146 and the diastolic result was 100. Review of documented vitals for the residents dated 12/17/24 revealed: -Every resident in the facility had blood pressures checked and the results were documented on a handwritten piece of paper. -Resident #3's blood pressure results was 151/101. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/10/24 at 3:20pm revealed: -Resident #3 had an order for amlodipine besylate 5mg once daily but it had expired. -The primary care provider (PCP) had only authorized one medication refill on the last order. -Eleven tablets of amlodipine besylate 5mg were dispensed on 08/28/24. -Thirty tablets of amlodipine besylate 5mg were dispensed on 09/09/24. -No amlodipine besylate was dispensed in October 2024. -Ten tablets of amlodipine besylate 5mg were dispensed on 11/27/24. -The facility would have to request the next amlodipine besylate refill because it was not scheduled for cycle fill. -Resident #3's amlodipine was not on a cycle fill anymore because the pharmacy did not get a new order to refill the medication before the cycle started. -The pharmacy had requested a new order to refill Resident #3's amlodipine besylate 5mg on 11/27/24 but the PCP had denied the refill. Telephone interview with Resident #3's former PCP on 12/11/24 at 5:15pm revealed: -Resident #3 was ordered amlodipine 5mg once	{D 358}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 208 daily; a refill order was written on 11/27/24 for 30 tablets at the facility's request. -Resident #3 was ordered amlodipine for his high blood pressure. -If he was not administered the amlodipine as ordered his blood pressure could go up. -The facility should have followed the order as written for the medication. Interview with Resident #3 on 12/11/24 at 11:45am revealed: -He did not know if he took medication for his blood pressure. -He did not take as many pills as he used to. -He felt "okay". Interview with a MA on 12/10/24 at 2:08pm revealed Resident #3's amlodipine was not on the medication cart because it was out and had already been reordered. Interview with the MA on 12/12/24 at 10:56am revealed: -Resident #3 did not have amlodipine on the cart because it had not come in yet. -She pulled a sticker from the medication card and placed it on a sheet to give to the Director. -The Director reordered medications. -It took time to get medication from the pharmacy; she could not say how long it took. -She did not know how long Resident #3 had been without his amlodipine. -She did not know if Resident #3's amlodipine needed a new order. -She did not call the pharmacy and she did not contact PCPs, because that was the Director's responsibility. -She documented physically unable to take on the eMAR when a medication was not available to administer.	{D 358}		

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{D 358}	Continued From page 209 Interview with a second MA on 12/13/24 at 9:25am revealed: -She was not sure if Resident #3 was out of amlodipine. -She documented physically unable to administer if the medication was not on the medication cart. -She let the Director know when a medication was not on the cart and the Director would reorder it. Interview with the Director on 12/12/24 at 3:15pm revealed: -The MA told her that morning, 12/12/24, Resident #3 and other residents were out of medications. -She did not know how long he was out of his amlodipine; she was only told today. -The MA gave her a piece of paper the MA had documented the medications Resident #3 was out of and the amlodipine was on the list. -The MAs were instructed to document physically unable to administer on the eMAR when a medication was not available to administer. -She did not think the MAs would document the medications as administered if they did not administer them. -It was "scary Resident #3 did not have all his medications because of what could happen to him without them". Telephone interview with the Administrator on 12/17/24 at 2:15pm revealed: -The PCP ordered Resident #3's amlodipine for a reason. -The medication should have been in the facility so it could be administered as ordered. -He was concerned for Resident #3's blood pressure without the medication and wanted the staff to monitor them until the medication came	{D 358}		

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{D 358}	Continued From page 210 in. -He relied on the MAs to tell the Director when a medication was not available for administration. -The Director was responsible for ensuring the medication was in the facility to be administered to the residents. Refer to the interview with a MA on 12/10/24 at 1:14pm. Refer to the interview with the Director on 12/12/24 at 3:15pm. Refer to the interview with the Director on 12/16/24 at 2:45pm. Refer to the telephone interview with the Administrator on 12/17/24 at 2:42pm. b. Review of Resident #3's most recent FL-2 dated 11/06/23 revealed there was an order for metoprolol succinate (used to lower high blood pressure) 100mg once daily. Review of Resident #3's physician's order dated 10/08/24 revealed: -There was an order for metoprolol succinate 100mg once daily. -The order was for thirty tablets with zero refills and do not refill was checked off. Review of Resident #3's MAR for October 2024 revealed: -There was an entry for metoprolol succinate 100mg once daily scheduled at 8:00am. -Metoprolol succinate was documented as administered once daily for 31 of 31 opportunities from 10/01/24 to 10/31/24. Review of Resident #3's eMAR for November	{D 358}		

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{D 358}	Continued From page 211 2024 revealed: -There was an entry for metoprolol succinate 100mg once daily scheduled at 8:00am. -Metoprolol succinate was documented as administered once daily for 15 of 30 opportunities from 11/01/24 to 11/30/24. -Metoprolol succinate was documented as physically unable to take 11 times from 11/14/24 to 11/24/24 and four times from 11/26/24 to 11/29/24. -Metoprolol was documented in the notes on the eMAR as waiting on the pharmacy on 11/23/24, 11/24/24, and 11/26/24. Review of Resident #3's eMAR for December 2024 from 12/01/24 to 12/13/24 revealed: -There was an entry for metoprolol succinate 100mg once daily scheduled at 8:00am. -Metoprolol succinate was documented as administered once daily 10 of 13 opportunities from 12/01/24 to 12/13/24. -Metoprolol was documented as physically unable to take three times on 12/11/24, 12/12/24, and 12/13/24. Observation of Resident #3's medication on hand on 12/10/24 at 2:08pm revealed: -Ten tablets of metoprolol succinate 100mg were dispensed on 11/27/24; the bubble pack was empty. -The medication pharmacy label had 0 refills typed on the top right corner. -There was no other metoprolol succinate available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/10/24 at 3:20pm revealed: -Resident #3 had an order for metoprolol 100mg once daily.	{D 358}		

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{D 358}	Continued From page 212 -He did not have any more refills on the order for the metoprolol. -The PCP had only written the order for thirty days and there were no more refills. -Metoprolol was a long-term medication but the pharmacy needed a new order to refill it. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/16/24 at 12:51pm revealed: -Resident #3's metoprolol was not on a cycle fill and had to be requested by the facility for a refill. -Thirty tablets of metoprolol were dispensed on 09/09/24 and 10/08/24. -Ten tablets of metoprolol were dispensed on 11/27/24. -There was a new order for refill dated 12/13/24 for Resident #3's metoprolol. -Twenty-four tablets of metoprolol would be dispensed to the facility on 12/16/24 for Resident #3. Telephone interview with Resident #3's former PCP on 12/17/24 at 12:07pm revealed: -Resident #3 was ordered metoprolol 100mg once daily for high blood pressure. -If Resident #3 missed a single dose it would cause his blood pressure to run high. -She considered consistently raised blood pressures a concern and he needed to be on the medication. -He needed to be administered the medication as ordered because when he missed doses his blood pressure could consistently remain elevated and he would be at increased risk for stroke or heart attack. -She expected the medication to be administered as ordered and administered consistently. Interview with Resident #3 on 12/11/24 at	{D 358}		

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{D 358}	Continued From page 213 11:45am revealed: -He did not know if he took medication for his blood pressure. -He did not take as many pills as he used to. -He felt "okay". Interview with a MA on 12/10/24 at 2:15pm revealed: -She knew Resident #3's metoprolol was out; she had pulled the reorder sticker off to reorder it today, 12/10/24. -She had administered the last tablet that morning and it would be reordered and available the next day. Interview with the MA on 12/12/24 at 10:56am revealed: -Resident #3 did not have metoprolol on the medication cart because it had not come in yet. -She pulled a sticker from the medication card and placed it on a sheet to give to the Director on 12/10/24. -The Director reordered medications; she was on top of it and the medication would be in by the next morning. -It took time to get medication from the pharmacy; she could not say how long it took. -He had been without the metoprolol since 12/10/24; she thought it would be delivered today, 12/12/24. -She did not know if Resident #3's metoprolol needed a new order. -She did not call the pharmacy and she did not contact PCPs, because that was the Director's responsibility. -She documented physically unable to take on the eMAR when a medication was not available to administer. Interview with a second MA on 12/13/24 at	{D 358}		

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{D 358}	Continued From page 214 9:25am revealed: -She could not remember Resident #3 being out of metoprolol. -She documented physically unable to administer if the medication was not on the medication cart. -She let the Director know when a medication was not on the medication cart and she would reorder it. Interview with the Director on 12/12/24 at 3:15pm revealed: -The MA told her that morning, 12/12/24, Resident #3 and other residents were out of medications. -The MA gave her a piece of paper she had written medications Resident #3 was out and the metoprolol was on the list. -She did not know how long he was out of his metoprolol. -The MAs were instructed to document physically unable to administer on the eMAR when a medication was not available to administer. -She did not think the MAs would document the medications as administered if they did not administer them. -It was "scary Resident #3 did not have all his medications because of what could happen to him without them". Telephone interview with the Administrator on 12/17/24 at 2:15pm revealed: -The PCP ordered the Resident #3 metoprolol for him for a reason. -The medication should have been in the facility so it could be administered as ordered. -He was concerned for Resident #3's blood pressure without the medication and wanted the staff to monitor his blood pressure until the medication came in. -He relied on the MAs to relay to the Director	{D 358}		

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when a medication was not available for administration.
-The Director was responsible for ensuring the medication was in the facility to be administered to residents.

Refer to the interview with a MA on 12/10/24 at 1:14pm.

Refer to the interview with the Director on 12/12/24 at 3:15pm.

Refer to the interview with the Director on 12/16/24 at 2:45pm.

Refer to the telephone interview with the Administrator on 12/17/24 at 2:42pm.

c. Review of Resident #3's most recent FL-2 dated 11/06/23 revealed there was an order for divalproex sodium (used to treat manic and mood disorders) extended release (ER) 500mg three tablets at bedtime.

Review of Resident #3's MAR for October 2024 revealed:
-There was an entry for divalproex sodium ER 500mg three tablets at bedtime for bipolar scheduled at 8:00pm.
-There was documentation divalproex was administered once daily 28 of 30 opportunities from 10/01/24 to 10/31/24; there was nothing documented for 10/29/24 and 10/31/24.

Review of Resident #3's eMAR for November 2024 revealed:
-There was an entry for divalproex sodium ER 500mg three tablets at bedtime for bipolar scheduled at 8:00pm.
-There was documentation divalproex was

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administered once daily 27 of 30 opportunities from 11/01/24 to 11/30/24.
-Divalproex was documented as physically unable to take on 11/18/24, and 11/19/24.
-Divalproex was documented as physically unable to take on 11/22/24 with a note, it had not come in from the pharmacy.

Review of Resident #3's eMAR for December 2024 from 12/01/24 to 12/13/24 revealed:
-There was an entry for divalproex sodium ER 500mg three tablets at bedtime for bipolar scheduled at 8:00pm.
-There was documentation divalproex was administered once daily 8 of 13 opportunities from 12/01/24 to 12/13/24.
-Divalproex was documented as physically unable to take on 12/07/24. 12/08/24, 12/11/24, and 12/12/24.
-Divalproex was documented as physically unable to take on 12/07/24 with a note, waiting for it to come in from the pharmacy.

Observations of Resident #3's medication on hand on 12/10/24 at 2:08pm and 12/12/24 at 10:56am revealed there was no divalproex sodium available for administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/10/24 at 3:20pm revealed:
-Resident #3 had an order for divalproex ER 500mg three tablets at bedtime; the order was dated 08/06/24.
-A thirty-day supply of 90 tablets was dispensed on 08/06/24.
-A thirty-day supply of 90 tablets was dispensed on 09/05/24.
-There were no other dispense dates because there were no more refills on the order; there

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needed to be a new order to refill the medication.
-The pharmacy had reached out to the physician and the facility for 8 weeks attempting to get a new order for Resident #3's divalproex.
-The pharmacy had not heard back from the physician or the facility.
-Resident #3 was on an extended release (ER) for divalproex.
-Divalproex ER was not recommended to be immediately stopped; usually the dosage was changed to an immediate release and/or lowered prior to stopping the medication.

Telephone interview with Resident #3's mental health provider (MHP) on 12/12/24 at 11:45am revealed:
-Resident #3 had an active order for divalproex sodium ER 500mg take three tablets to equal 1500mg at bedtime.
-The facility had not contacted her about any issues or concerns with Resident #3's divalproex.
-She visited Resident #3 on 10/15/24 and wrote an new order with five refills for his divalproex.
-Her office sent the order to the pharmacy when she wrote the order.
-The facility staff should call the pharmacy to verify the order was received if the medication was not delivered.
-When she visited Resident #3 on 12/02/24 and reviewed his eMAR; his divalproex was documented as administered as ordered on the eMAR.
-Resident #3 had a history of bipolar disorder and was ordered divalproex because it was for mood stabilization.
-Divalproex was usually weaned off with dosage reduction when it was stopped.
-She would have reduced the divalproex dosage to 1000mg then 500mg over a week or so to prevent stopping it abruptly.

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-Reducing divalproex in his system prevented any side effects like gait disturbance.
-She expected the facility to make sure Resident #3's divalproex was on the medication cart for administering and for them to reach out to her if there was an issue getting the medication from the pharmacy.
-Resident #3 could have mood swings, been hard to redirect and have difficult behaviors without the divalproex.
-There had been no reported behaviors or changes to Resident #3 by the staff.
-There were no changes to the divalproex order, so she expected the facility to administer the medication as ordered.

Interview with Resident #3 on 12/11/24 at 11:45am revealed:
-He took divalproex at one time but they [staff] did not give him those pills anymore.
-He thought he took divalproex to "help heal" him and make him feel better.
-He felt "okay".
-He did not take as many pills as he used to.

Interview with a MA on 12/10/24 at 2:08pm revealed Resident #3's divalproex was not on the medication cart because it was out and had already been reordered.

Interview with a MA on 12/12/24 at 10:56am revealed:
-Resident #3 did not have divalproex on the medication cart because it had not come from the pharmacy yet.
-She pulled a sticker from the medication card and placed it on a sheet to give to the Director; she did not know when.
-The Director reordered medications.
-It took time to get medication from the pharmacy;

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{D 358}	Continued From page 219 she could not say how long it took. -She did not know how long Resident #3 had been without his divalproex, but they had been waiting for it. -His mood had been good, and he was not acting any different. -She asked him every day how he was doing, and he would say he was okay. -She did not know if Resident #3's divalproex needed a new order. -She did not call the pharmacy and she did not contact PCPs, because that was the Director's responsibility. -She documented physically unable to take on the eMAR when a medication was not available to administer. -If she had documented she administered the medication when it was not available then she made a mistake when she documented. Interview with a second MA on 12/13/24 at 9:25am revealed: -She was not sure if Resident #3 had been out of divalproex. -She documented physically unable to administer if the medication was not on the cart. -She let the Director know when a medication was not on the medication cart and she would reorder it. Interview with the Director on 12/12/24 at 3:15pm revealed: -The MA told her that morning, 12/12/24, Resident #3 and other residents were out of medications. -The MA gave her a piece of paper she had written medications Resident #3 was out of and the divalproex was on the list. -She was not sure how long he was out of his divalproex.	{D 358}		

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{D 358}	Continued From page 220 -She knew Resident #3's MHP ordered the divalproex for him and she reached out to the MHP today, 12/12/24. -The MHP was at the facility in October 2024 and she let the MHP know at that time Resident #3 needed a refill order for the divalproex. -She did not follow up to see if his divalproex had been ordered or if it had come in; she did not know why she did not follow-up on the order. -Staff had not told her Resident #3 was completely out of his divalproex. -The MHP always asked if there were any concerns when she visited the residents, but she did not know in November 2024 or December 2024 when the MHP was at the facility that he was out of the divalproex. -The staff, including the MAs and herself should have caught Resident #3 did not have his divalproex to administer. -The MAs were instructed to document physically unable to administer on the eMAR when a medication was not available to administer and note why. -She would be surprised if the MAs documented the divalproex as administered if they did not administer it; she did not think they would do that. -It was "scary Resident #3 did not have all his medications because of what could happen to him without them". -He had not had any changes in his behaviors or moods. Telephone interview with the Administrator on 12/17/24 at 2:15pm revealed: -The MHP ordered the Resident #3 divalproex for a reason. -He expected the divalproex to be in the facility and to be administered as ordered. -Resident #3 needed the divalproex to keep his moods stable; he had not noticed or thought there	{D 358}		

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MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 221	{D 358}		

was any change in his mood.
-The MAs should not document the medication as administered if it was not in the facility because the MHP and PCP reviewed the eMARs when they visited and relied on the information on them to be accurate.
-He relied on the MAs to relay to the Director when a medication was not available for administration.
-The Director was responsible for ensuring the medication was in the facility to be administered to residents.

Refer to the interview with a MA on 12/10/24 at 1:14pm.

Refer to the interview with the Director on 12/12/24 at 3:15pm.

Refer to the interview with the Director on 12/16/24 at 2:45pm.

Refer to the telephone interview with the Administrator on 12/17/24 at 2:42pm.

7. Review of Resident #6's current FL-2 dated 05/17/24 revealed:
-Diagnoses included asthma, hypertension, diabetes mellitus, and schizophrenic disorder.
-There was an order for Advair (used to treat asthma) 250-50 diskus inhale one puff twice daily.

Review of Resident #6's electronic medication administration record (eMAR) for November 2024 revealed:
-There was an entry for Advair 250-50mcg diskus inhale 1 puff twice daily scheduled at 8:00am and 8:00pm.
-Advair was documented as administered 54 for

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{D 358}	Continued From page 222 of 54 opportunities from 11/0124 to 11/30/24. -Advair was documented as administered twice daily from 11/01/24 to 11/17/24 and 11/22/24 to 11/30/24. -Resident #6 was documented as out of the facility from 11/18/24 to 11/21/24. -Advair was documented as administered once on 11/18/24 and 11/21/24. Review of Resident #6's eMAR for December 2024 from 12/01/24 to 12/13/24 revealed: -There was an entry for Advair 250-50mcg diskus inhale 1 puff twice daily scheduled at 8:00am and 8:00pm. -Advair was documented as administered 22 of 25 opportunities. -Advair was documented as physically unable to take 3 times from 12/13/24 to 12/13/24. Observation of Resident #6's medications on hand on 12/13/24 at 3:17pm revealed: -There was an Advair 250-50mcg inhaler with 14 actuations dispensed on 11/01/24 in a box that was in a small resealable bag with the pharmacy medication label on the outside. -There was a sticker on the bag for documenting the open date of the inhaler and instructions that it expired one month after opening. -There was no open date on the sticker, the inhaler or the packaging. -There was a "refill after" date of 11/07/24 on the package. -The actuation counter indicated there were 12 inhalations available for administering. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/16/24 at 12:51pm revealed: -Resident #6 had an order for Advair 250-50mcg inhale one puff twice daily.	{D 358}		

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{D 358}	Continued From page 223 -An Advair inhaler with 14 actuations for a 7-day supply was dispensed on 11/01/24. -There was a counter on the diskus that counted down the number of available inhalations each time it was used. -The 14-dose inhaler may have been the only supply the pharmacy had to send so the medication label had the order that could be refilled after 11/07/24. -Resident #6's Advair was not on a cycle fill; the facility had to request a refill. -Advair was used to treat asthma and breathing difficulty and was needed for long term use. -Advair was a steroid for longer acting treatment, but if doses were missed for more than a day or two the resident could experience shortness of breath until exasperated with more symptoms. -A new order had been written on 12/13/24 and a new Advair diskus with a 30-day supply was dispensed on 12/13/24. Interview with Resident #6 on 12/16/24 at 9:55am revealed: -He used an inhaler almost every day; he had used the inhaler that morning, 12/16/24. -He used the inhaler twice a day. -He did not use the inhaler for a while because it ran out. -It took about a week for the new inhaler to come in, he just got the new one today. -He had not had any trouble with his breathing. Telephone interview with Resident #6's former primary care provider (PCP) on 12/17/24 at 12:07pm revealed: -Resident #6 was ordered Advair inhale one puff twice daily for his asthma. -Advair was a maintenance medication. -It would be okay for Resident #6 to miss a dose a couple of times, but this time of the year there	{D 358}		

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was an increased affect for residents with asthma, so it was more crucial for it to be administered daily.
-If he missed over a week at a time there would be an increased risk of exasperation like shortness of breath and wheezing.
-She expected his medication to be administered per the order and with consistency.

Interview with a medication aide (MA) on 12/16/24 at 5:25pm revealed:
-She did not know how many inhalations were on Resident #6's Advair when he got it.
-She did not always look at the actuation counter when she administered it.
-She administered the one on the cart that was not used up.
-She did not know they needed to be discarded 30 days after they were opened.
-She did not open the inhaler, so she did not write an open date on it.
-The package said refill after "some date in November 2024".
-She administered Resident #6 his Advair; he did not refuse it.
-She did not administer it after she was told on 12/10/24 that it could not be used because it had been opened for more than thirty days.
-She asked him every day how he was, and he was always "fine".

Interview with the Director on 12/16/24 at 3:00pm revealed:
-Resident #6 had problems getting his Advair because of insurance.
-He had been in the hospital for two days in November 2024, she thought he still had the inhaler because he missed one or two days while at the hospital.
-Those should have been the only two days he

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was not administered the inhaler.
-She had seen the Advair on the medication cart the last time she did cart audits about two weeks before 12/08/24.
-She did not look at the counter to see how many inhalations were left.
-She did not know the Advair that was on the medication cart only had 14 inhalations in it; the Advair inhalers usually had 60.
-She was not sure if staff administered Resident #6 his Advair, because she had not looked at the eMAR.
-The Advair should not have lasted very long and should not have been on the medication cart in December 2024.
-The staff did not tell her about any problems with his Advair inhaler until after 12/10/24.
-Inhalers were not on a cycle fill and had to be reordered when needed.

Telephone interview with the Administrator on 12/17/24 at 2:15pm revealed:
-Resident #6 was ordered the Advair inhaler for breathing.
-He expected the Advair to be in the facility so it could be administered as ordered.
-Resident #6 should have been administered the Advair twice a day as ordered; he was concerned it was for breathing had not been administered to the resident.
-The MAs should not document the medication as administered if it was not in the facility because the PCP reviewed the eMARs when they visited and relied on the information on them to be accurate.
-He relied on the MAs to relay to the Director when a medication was not available for administration.
-The Director was responsible for ensuring the medication was in the facility to be administered

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{D 358}	Continued From page 226 to residents. Refer to the interview with a MA on 12/10/24 at 1:14pm. Refer to the interview with the Director on 12/12/24 at 3:15pm. Refer to the interview with the Director on 12/16/24 at 2:45pm. Refer to the telephone interview with the Administrator on 12/17/24 at 2:42pm. 8. Review of Resident #13's current FL-2 dated 06/05/24 revealed: -Diagnoses included schizophrenia, tremor, bipolar disorder and hypertension. -There was an order for losartan-hydrochlorothiazide (used to treat high blood pressure) 100mg-25mg once daily. Review of Resident #13's electronic medication administration record (eMAR) for November 2024 revealed: -There was an entry for losartan-hydrochlorothiazide 100mg-25mg once daily scheduled at 9:00am. -Losartan-hydrochlorothiazide was documented as administered 21 of 30 opportunities from 11/01/24 to 11/30/24. -Losartan-hydrochlorothiazide was documented as physically unable to take 9 times from 11/13/24 to 11/21/24. -Losartan- hydrochlorothiazide was documented on the eMAR notes as waiting on the pharmacy on 11/21/24. -There was an entry for blood pressure checks twice daily scheduled at 8:00am and 8:00pm. -The entry was to check blood pressures prior to	{D 358}		

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{D 358}	Continued From page 227 administering any and all blood pressure medications and to notify the PCP if blood pressure results were less than 90 diastolic over 60 systolic or greater than 160 diastolic over 90 systolic. -There was documentation the resident's blood pressures were 194/121 on 11/05/24, 185/104 on 11/14/24, 187/120 on 11/17/24 and 195/110 on 11/18/24. Review of Resident #13's eMAR for December 2024 from 12/01/24 to 12/13/24 revealed: -There was an entry for losartan-hydrochlorothiazide 100mg-25mg once daily scheduled at 9:00am. -Losartan-hydrochlorothiazide was documented as administered 7 of 13 opportunities from 12/01/24 to 12/13/24. -Losartan-hydrochlorothiazide was documented as physically unable to take 6 times from 12/08/24 to 12/13/24. -There was an entry for blood pressure checks twice daily scheduled at 8:00am and 8:00pm. -There was an entry to check blood pressures prior to administering any and all blood pressure medications and to notify the PCP if blood pressure results were less than 90 diastolic over 60 systolic or greater than 160 diastolic over 90 systolic. -There was documentation the resident's blood pressures were 166/112 on 12/02/24, 169/114 on 12/09/24, 164/104 on 12/10/24, and 178/74 on 12/12/24. Observation of Resident #13's medication on hand on 12/13/24 at 2:24pm revealed there was no losartan-hydrochlorothiazide available for administration. Observation of Resident #13's blood pressure	{D 358}		

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{D 358}	Continued From page 228 check on 12/16/24 at 9:05am revealed his blood pressure was 138/85. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/16/24 at 12:51pm revealed: -Resident #13 had an order for losartan-hydrochlorothiazide 100mg-25mg once daily. -Fourteen tablets of losartan-hydrochlorothiazide were dispensed on 09/24/24. -Thirty tablets of losartan-hydrochlorothiazide were dispensed on 10/04/24. -Sixteen tablets of losartan-hydrochlorothiazide 100mg-25mg were dispensed on 11/21/24. -An order to refill Resident #13's losartan-hydrochlorothiazide 100mg-25mg was dated 12/13/24 for only thirty tablets. -Thirty tablets of losartan-hydrochlorothiazide 100mg-25mg would be dispensed today, 12/16/24. Telephone interview with Resident #13's former primary care provider (PCP) on 12/17/24 at 12:07pm revealed: -Resident #13 was ordered losartan-hydrochlorothiazide 100mg-25mg once daily for his hypertension. -His blood pressure was high and missing a single dose would not be a concern but if he missed more than a couple of doses it would increase the risk for high blood pressure. -If he consistently continued to miss multiple doses he would be at risk for a stroke or a heart attack. -If the resident was not administered his medication consistently then his blood pressures should have been monitored to make sure they were not elevated. -She expected the order to be followed and the	{D 358}		

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{D 358}	Continued From page 229 losartan-hydrochlorothiazide to be administered daily. Interview with Resident #13 on 12/16/24 at 5:28pm revealed: -He did not know what medications he took. -He thought he had high blood pressure and took medication for it. -He knew they checked his blood pressure, but he was not sure when or what the results were. Interview with a medication aide (MA) on 12/16/24 at 5:25pm revealed: -Resident #13's losartan-hydrochlorothiazide was still not in yet. -His losartan-hydrochlorothiazide had been reordered sometime last week. -She only knew it was not on the medication cart to administer to him. Interview with the Director on 12/16/24 at 3:00pm revealed: -She knew Resident #13 did not have his losartan-hydrochlorothiazide because it was not on the medication cart when she checked on 12/08/24; it was not on the medication cart in November 2024 when she did the audits. -She never thought to look at the eMAR to see if the medications were being administered. -Resident #13 needed a refill order for his losartan-hydrochlorothiazide and she could not get the former PCP to write a refill order. -She did not know what to do about Resident #13's losartan-hydrochlorothiazide. -She did not tell the Administrator she could not get Resident #13's losartan-hydrochlorothiazide; she thought she was handling it. -The MAs were supposed to document physically unable to administer if the medication was not in the facility.	{D 358}		

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{D 358}	Continued From page 230 Telephone interview with the Administrator on 12/17/24 at 2:15pm revealed: -Resident #13 was ordered the losartan-hydrochlorothiazide by the PCP for a reason. -He expected the losartan-hydrochlorothiazide to be in the facility and to be administered as ordered. -Resident #13's blood pressure should have been monitored while the medication was not administered. -The MAs should not document the medication as administered if it was not in the facility because the PCP reviewed the eMARs when they visited and relied on the information on them to be accurate. -He relied on the MAs to tell the Director when a medication was not available for administration. -The Director was responsible for ensuring the medication was in the facility to be administered to residents. 9. Review of Resident #2's current FL-2 dated 09/10/24 revealed: -Diagnoses included hypertension and peripheral artery disease. -There was an order for Clonidine (used to treat high blood pressure (BP)) 0.3mg three times daily. Review of Resident #2's October 2024 paper medication administration record (MAR) from 10/10/24-10/31/24 revealed: -There was an entry for Clonidine 0.3mg three times daily with scheduled administration times of 9:00am, 3:00pm, and 9:00pm. -There was documentation Clonidine 0.3mg was not administered on 10/29/24 and 10/31/24 at	{D 358}		

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3:00pm and 9:00pm.
-There were no exceptions documented.

Review of Resident #2's November 2024 electronic MAR (eMAR) revealed:
-There was an entry for Clonidine 0.3mg three times daily with scheduled administration times of 8:00am, 2:00pm, and 8:00pm.
-There was documentation Clonidine 0.3mg was not administered on 26 occasions from 11/02/24-11/25/24 with the exception documented as physically unable to take.

Review of Resident #2's December 2024 eMAR from 12/01/24-12/13/24 revealed:
-There was an entry for Clonidine 0.3mg three times daily with scheduled administration times of 8:00am, 2:00pm, and 8:00pm.
-There was documentation Clonidine 0.3mg was not administered on 12/09/24 at 2:00pm and 8:00pm with the exception documented as physically unable to take.
-Clonidine was documented as administered three times daily from 12/01/24-12/08/24 and 12/10/24-12/13/24.

Review of Resident #2's monthly BPs for November 2024 and December 2024 revealed:
-On 11/01/24, Resident #2's BP was documented as 157/119.
-On 11/15/24, Resident #2's BP was documented as 148/89.
-On 12/01/24, Resident #2's BP was documented as 138/75.

Observation of Resident #2's blood pressure on 12/12/24 at 10:13am revealed a BP reading of 114/81.

Observation of Resident #2's medications on

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hand on 12/10/24 at 2:41pm revealed:
-Two punch cards labeled as Clonidine 0.3mg were dispensed on 11/21/24; 48 tablets were dispensed.
-The punch card labeled as 1 of 2 had no tablets remaining in the card; 18 tablets had been punched.
-The card labeled 2 of 2 had one tablet remaining in the card; 29 tablets had been punched.
-There was documentation on the pharmacy label that 42 tablets were remaining on the prescription.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/11/24 at 10:05am revealed:
-Resident #2's Clonidine 0.3mg with the directions to take three times daily was dispensed on 09/02/24 for 90 tablets, 10/02/24 for 18 tablets, 10/22/24 for 48 tablets, 11/21/24 for 48 tablets and 12/10/24 for 78 tablets.
-When the pharmacy tried to fill Resident #2's Clonidine for the October cycle fill, the prescription had run out.
-On 10/02/24, a prescription was received for a 30-day supply and 18 tablets were dispensed to try to get the medication back in line with the next cycle fill.
-On 10/22/24, the facility staff contacted the pharmacy for a refill on the Clonidine.
-On 10/22/24, the pharmacy's system showed 48 tablets of Clonidine were needed to get to the next cycle and 48 tablets were dispensed.
-On 11/21/24, another prescription was received for a 30-day supply and 48 tablets were dispensed to get the facility to the next cycle.
-On 12/10/24, another prescription was received for a 30-day supply and 78 tablets were dispensed.
-Cycle medication was sent out a couple of days

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ahead of when the facility would begin the cycle.
-An example would be medication for the current cycle was shipped out between 12/03/24-12/04/24 to be started on 12/07/24.
-Clonidine was used to treat high blood pressure.

Interview with Resident #2 on 12/10/24 at 4:00pm revealed:
-He did not "really know" what medication he was administered daily.
-He was supposed to take a BP medication, but he did not know if the medication was in his "cup" every day.
-He had a headache "here and there."
-He thought staff checked his BP once a month, he did not know what his BP readings were.

Interview with a medication aide (MA) on 12/13/24 at 9:04am revealed:
-Exceptions documented as physically unable to take meant the medication was not available to be administered.
-She recalled Resident #2 did not have Clonidine available to be administered.
-She circled her initials on the paper MAR/eMAR and let the Director know the medication was not on the medication cart.
-She did not tell the Director every day the medication was not on the cart, just randomly.
-She did not check Resident #2's BP when she worked.

Interview with a second MA on 12/17/24 at 11:00am revealed:
-Initials that were circled on the MARs meant Resident #2's Clonidine was not administered.
-The exceptions documented as physically unable to take meant the medication was not available to be administered.
-Resident #2's Clonidine finally came in but she

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 234 did not recall when. Telephone interview with Resident #2's former primary care provider (PCP) on 12/11/24 at 4:31pm revealed: -Clonidine was used to treat high BP. -She would be concerned if the resident missed multiple doses of Clonidine, because the resident could have elevated BPs. -If Resident #2's BP was consistently high he could be at risk of a stroke or heart attack. Interview with the Director on 12/17/24 at 3:11pm revealed: -She was aware Resident #2 missed multiple doses of Clonidine. -She thought Resident #2's Clonidine was one of the medications that she received a notification from the pharmacy that the prescription did not have any refills. -She had requested a refill from the former PCP. Interview with the Administrator on 12/17/24 at 5:49pm revealed: -If Resident #2 was out of Clonidine, he expected the Director to determine why the medication was not on the medication cart and to get the medication in. -He expected the Director to make sure the prescription for Resident #2's Clonidine was up to date so the medication was available. -He expected Resident #2 to be administered his Clonidine as ordered. -He was concerned Resident #2's BP was not controlled if his BP medication was not administered as ordered. Refer to the interview with a MA on 12/10/24 at 1:14pm.	{D 358}		

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{D 358}	Continued From page 235 Refer to the interview with the Director on 12/12/24 at 3:15pm. Refer to the interview with the Director on 12/16/24 at 2:45pm. Refer to the telephone interview with the Administrator on 12/17/24 at 2:42pm. _____ Interview with a MA on 12/10/24 at 1:14pm revealed: -When a medication was not available to be administered, she documented "resident physically unable to take". -She would pull the re-order sticker from the prescription label and then she gave the sticker to the Director when a medication needed to be reordered. -The Director was responsible for reordering medications. Interview with the Director on 12/12/24 at 3:15pm revealed: -There was a sticker located on each medication label that was removed by the MAs and put on a refill sheet that she faxed to the pharmacy when medication needed a refill. -She kept a copy of the medication refill sheet she faxed to the pharmacy. -The pharmacy sent a medication manifest with the medication delivery. -She compared the medication refill sheet with the medication manifest the pharmacy provided. -If a medication was not delivered per the medication manifest, then she called the pharmacy to check. -If the pharmacy had an issue with an order or insurance, she would scan a request for the medication to the PCP or do telehealth with the PCP.	{D 358}		

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{D 358}	Continued From page 236 -The PCP would sign off on the request or send an escript (electronic prescription) to the pharmacy and the medication would come in. -She had sent a list of specific medications to the former PCP about two weeks ago in an attempt to get refill orders for medications. -She currently could not do telehealth with the former PCP; she did not know what to do to get refill orders for some of the residents' medications. -After 11/30/24 she no longer had access to the telehealth system because the facility was no longer serviced by the former PCP. -If she faxed the refill order in the morning the medication would be delivered by between 11:00am-4:00pm. -When the medication was delivered at 2:00am, they slid the order manifest medication manifest under her door. -She reviewed the medication list when it was delivered by the pharmacy with the medication manifest the pharmacy provided when it delivered the medication. Interview with the Director on 12/16/24 at 2:45pm revealed: -She did cart audits about every two weeks and documented the audits. -She checked the medication carts to see if medications were on the cart. -She audited random residents' medications when she did the audits. -She looked at medications for expiration dates, beginning dates and end dates for the orders. -She looked at the amounts of tablets that were still available for administration to see if they needed to be reordered. -The cycle fill medications were all started on the evening they were dispensed from the pharmacy so the counts would all be the same in the	{D 358}		

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{D 358}	Continued From page 237 [bubble] packs. -The new medication cards were placed on the medication carts and the old [bubble] packs were removed. -Unused medication in [bubble] packs were returned to the pharmacy; even if there was one tablet left so the counts would be the same. -She compared the order on the eMAR to the order on the medication label. -She did not look at the counters of inhalers and she did not look for open dates on medications. -Inhalers, creams, eyedrops and nose sprays were not on cycle fill and had to be requested for refill. -The last audit she did was two weeks before 12/08/24 when she realized some medications needed refill orders. -When the Administrator came to the facility, he would ask if the residents had their medications and if the medications had been administered correctly. -She did not inform the Administrator about the medications that needed to have new orders to refill them. Telephone interview with the Administrator on 12/17/24 at 2:42pm revealed: -The Director should check when medications were delivered to the facility to ensure all ordered medications were delivered. -The Director should check the medication cart bi-weekly to make sure all medications were on hand to be administered. -He was concerned that it did not appear this process was being done, or not consistently because missed medications would not be an issue. -He expected all residents to be administered their medication as ordered by the PCP. _____	{D 358}		

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{D 358}	Continued From page 238 The facility failed to administer medications as ordered to 9 of 9 residents, including Resident #1 who had multiple falls, was seen in the ED 8 times from 10/21/24-10/31/24 and was admitted to the hospital on 10/31/24 with a diagnosis of orthostatic hypotension and his BP medications were discontinued. The resident returned to the facility on 11/19/24 and the BP medications continued to be administered, and the resident had three additional falls from 11/26/24-12/06/24, two of which required hospitalizations. On 12/06/24, the resident had a fall at the facility and was sent to the ED, where he went into cardiac arrest, was intubated and placed on life support. Resident #11 had multiple seizures, was seen in the ED 3 times from 11/09/24-11/16/24 and was ordered a seizure medication upon discharge from the facility which was only administered 3 of 18 days which put him at risk for additional seizures. Resident #3, diagnosed with hypertension and had BP readings of 146/100 and 151/101, was not administered 47 doses of one medication to control BP and was not administered 21 doses of a second medication used to control BP because his medication order could not be refilled. Resident #13 diagnosed with hypertension with BP readings of 166/112, 169/114, 164/104, and 178/74 missed 26 doses of a medication used to control BP. Resident #2 diagnosed with hypertension missed more than 26 doses of a medication used to control BP. This failure resulted in serious neglect which constitutes an unabated type A1 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/24. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 16, 2025.	{D 358}		

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{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration record (MAR) was accurate for 8 of 10 sampled residents (#1, #2, #3, #5, #6, #7, #8, #9) including the administration of an insulin (#1); a pain medication (#2); an insulin (#3), two insulins, an anti-anxiety medication, and a blood pressure medication (#5); an insulin, an inhaler and a blood pressure medication (#6); a cholesterol medication and a medication for abnormal movements (#7); a pain medication (#8); and a	{D 367}		

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{D 367}	Continued From page 240 sleep aid (#9). 1. Review of Resident #5's previous FL-2 dated 02/21/24 revealed diagnosis included diabetes. Review of Resident #1's signed physician orders dated 05/06/24 revealed: -There was an order to check and record blood sugar readings four times daily. -There was an order for Novolog (a fast-acting insulin used to lower blood sugar) sliding scale insulin (SSI) three times daily before meals as follows: 0 to 200 - 0 units; 201 to 250 - 2 units; 251 to 300 - 4 units; 301 to 350 - 6 units; 351 to 400 - 8 units; call the doctor if blood sugar was greater than 400. Review of Resident #1's October 2024 paper medication administration record (MAR) from 10/10/24 to 10/31/24 revealed: -There was an entry for blood sugar checks four times daily scheduled at 7:30am, 11:30am, 4:30pm, and 7:30pm. -There was documentation blood sugar readings were checked from 10/10/24 to 10/30/24 at 7:30am, 11:30am, 4:30pm and 7:30pm and on 10/31/24 at 7:30am, 11:30am, and 4:30pm. -There was no documentation on 10/31/24 at 7:30pm; the MAR was blank. -There was an entry for Novolog SSI as follows: 0 to 200 - 0 units; 201 to 250 - 2 units; 251 to 300 - 4 units; 301 to 350 - 6 units; 351 to 400 - 8 units; call MD if blood sugar was greater than 400 -There was documentation Novolog SSI was administered from 10/10/24 to 10/30/24 7:30am, 11:30am, and 4:30pm and on 10/31/24 at 7:30am; there was no documentation of how many units of Novolog SSI was administered. -There was no documentation on 10/31/24 at 11:30am and 4:30pm; the MAR was blank.	{D 367}		

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{D 367}	Continued From page 241 Telephone interview with the Pharmacist from the facility's contracted pharmacy on 12/11/24 at 2:04pm revealed: -The pharmacy did not enter a place for the units of SSI to be documented onto the MAR. -The facility used paper MARs in October and the facility staff could hand write on the MAR a place to record the number of units administered to the resident. Interview with a medication aide (MA) on 12/12/24 at 2:41pm revealed: -She documented the number of units of insulin the resident was administered for elevated blood sugar readings in a personal small notebook. -She left the notebook at the facility, but she had not been able to locate the notebook. Interview with the Supervisor on 12/12/24 at 3:52pm revealed: -The number of units administered for a SSI order should be documented on the MAR. -There was room on the back of the paper MAR to document or the MAs could right it in on the front of the MAR. Interview with the Director on 12/16/24 at 5:03pm revealed: -The MAs should have documented the number of units administered with the SSI order on the MAR. -The MAs could have written it in on the paper MAR. -She did not know the MAs were not documenting the number of units of insulin that was being administered based on SSI order. -She had not been notified there was no place to document the number of units of insulin administered.	{D 367}		

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{D 367}	Continued From page 242 -She could add a place on the paper MAR to document the number of units of insulin administered. Telephone interview with the Administrator on 12/17/24 at 2:53pm. -The number of units of insulin administered for a SSI should be documented on the MAR. -The MAs could document on the front or the back of the paper MAR and could have the Director to add it on the MAR. 2. Review of Resident #5's current FL-2 dated 09/21/24 revealed diagnoses included diabetes mellitus, mitral valve prolapse, hypertension, and arthritis. a. Review of Resident #5's current FL-2 dated 09/21/24 revealed: -There was an order for blood sugar checks and record readings before meals and at bedtime. -There was an order for Novolog (a fast-acting insulin used to lower blood sugar) sliding scale insulin (SSI) three times daily before meals as follows: 0 to 200 - 0 units; 201 to 250 - 2 units; 251 to 300 - 4 units; 301 to 350 - 6 units; 351 to 400 - 8 units; 401 to 450 - 10 units; 451 to 500 - 12 units. Review of Resident #5's October 2024 paper medication administration record (MAR) from 10/10/24 to 10/31/24 revealed: -There was an entry to check blood sugar and record readings before meals and at bedtime. -There was documentation blood sugar readings were checked from 10/10/24 to 10/28/24 and on 10/30/24 at 7:30am, 11:30am, 4:30pm and 7:30pm; and on 10/29/24 and 10/31/24 at 7:30am. -There was no documentation blood sugar	{D 367}		

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{D 367}	Continued From page 243	{D 367}		

readings were obtained on 10/29/24 and 10/31/24 at 11:30am, 4:30pm and 7:30pm; the MAR was blank.
-There was an entry for Novolog sliding scale insulin as follows: 0 to 200 - 0 units; 201 to 250 - 2 units; 251 to 300 - 4 units; 301 to 350 - 6 units; 351 to 400 - 8 units; 401 to 450 - 10 units; 451 to 500 - 12 units with a scheduled administration time of 7:30am, 11:30am, and 4:30pm.
-There was documentation Novolog SSI was administered from 10/10/24 to 10/28/24 and on 10/30/24 at 7:30am, 11:30am, and 4:30pm; and on 10/29/24 and 10/31/24 at 7:30am and 11:30am; there was no documentation of how many units of Novolog SSI was administered.
-There was no documentation Novolog SSI was administered on 10/29/24 and 10/31/24 at 4:30pm; the MAR was blank.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 12/11/24 at 2:04pm revealed:
-The pharmacy did not enter a place for the units of SSI to be documented onto the MAR.
-The facility used paper MARs in October 2024 and the facility staff could hand write on the MAR a place to record the number of units administered to the resident.

Interview with a medication aide (MA) on 12/12/24 at 2:41pm revealed:
-She documented the number of units of insulin the resident was administered for elevated blood sugar readings in a personal small notebook.
-She left the notebook at the facility, but she had not been able to locate the notebook.

Interview with the Supervisor on 12/12/24 at 3:52pm revealed:
-The number of units administered for a SSI order

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{D 367}	Continued From page 244 should be documented on the MAR. -There was room on the back of the paper MAR to document or the MAs could right it in on the front of the MAR. Interview with the Director on 12/16/24 at 5:03pm revealed: -The MAs should have documented the number of units administered with the SSI order on the MAR. -The MAs could have written it in on the paper MAR. -She did not know the MAs were not documenting the number of units of insulin that was being administered based on SSI order. -She had not been notified there was no place to document the number of units of insulin administered. -She could had a place on the paper MAR to document the number of units of insulin administered. Telephone interview with the Administrator on 12/17/24 at 2:53pm. -The number of units of insulin administered for a SSI should be documented on the MAR. -The MAs could document on the front or the back of the paper MAR and could have the Director to add it on the MAR. b. Review of Resident #5's current FL-2 dated 09/21/24 revealed there was an order for Eliquis 5mg (used to treat and prevent blood clots) twice daily. Review of Resident #5's October 2024 MAR from 10/10/24 to 10/31/24 revealed: -There was an entry for Eliquis 5mg twice daily with a scheduled administration time of 8:00am and 8:00pm.	{D 367}		

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{D 367}	Continued From page 245 -There was documentation Eliquis was administered from 10/01/24 to 10/31/24 at 8:00am. -There was no documentation Eliquis was administered from 10/01/24 to 10/31/24 at 8:00pm; the MAR was blank. Interview with the a MA on 12/13/24 at 10:20am revealed: -She gave Resident #5 Eliquis each night and forgot to sign the paper MAR. -She always gave Resident #5 Eliquis as ordered. -She did not realize she forgot to sign the paper MAR. Interview with the Director on 12/16/24 at 5:03pm revealed: -The MAs should sign the MAR immediately after administration of the medication. -The MARs should be correct so when the PCP reviewed the MAR, the PCP would know how to adjust medications. Telephone interview with the Administrator on 12/17/24 at 2:53pm revealed: -The MAs should document administration of all medications. -They should verify that all medications administered have been signed off on the eMAR. c. Review of Resident #5's current FL-2 dated 09/21/24 revealed there was an order for Lantus (a long-acting insulin used to control high blood sugars) 55 units twice daily. Review of Resident #5's November 2024 eMAR revealed: -There was an entry for insulin glargine 55 units subcutaneous every day with a scheduled administration time of 8:00pm.	{D 367}		

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{D 367}	Continued From page 246 -There was documentation insulin glargine was administered daily from 11/01/24 to 11/30/24. -There was a second entry for Lantus 55 units subcutaneous at bedtime with a scheduled administration time of 8:00pm. -There was documentation Lantus was administered from 11/01/24 to 11/08/24 and from 11/10/24 to 11/30/24 at 8:00pm. -There was an exception documented on 11/09/24 at 8:00pm; the exception was the medication was on the eMAR twice. Review of Resident #5's December 2024 eMAR from 12/01/24 to 12/09/24 revealed: -There was an entry for insulin glargine 55 units subcutaneous every day with a scheduled administration time of 8:00pm. -There was documentation glargine was administered daily from 12/01/24 to 12/06/24 and from 12/08/24 to 12/09/24. -There was an exception documented on 12/07/24 at 8:00pm; the exception was the medication was on the eMAR twice. -There was a second entry for Lantus 55 units subcutaneous at bedtime with a scheduled administration time of 8:00pm. -There was documentation Lantus was administered at bedtime from 12/01/24 to 12/09/24. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 12/11/24 at 2:04pm revealed: -Lantus and insulin glargine were the same medication. -The pharmacy did not receive a call that Lantus was on the eMAR twice. -The pharmacy could have removed one of the entries if they had been notified.	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 247 Interview with a MA on 12/12/24 at 2:41pm revealed: -She notified the Director when a medication was on the eMAR twice. -When a duplicate order was on the eMAR, one should be signed when the medication was administered and the second entry should have an exception documented. She would document the exception physically unable to take or medication was on the eMAR twice. Interview with another MA on 12/13/24 at 8:06am revealed: -She did not know why there were two entries on the eMAR for the same medication. -She had notified the Director of duplicate entries for the same medication on the resident's eMAR, but the Director did not know how to remove one of the entries. -The Director was going to notify the pharmacy to see if they could remove one of the entries. -She would sign both entries because she did not know what else to do. -She had not been told what to do with the second entry, so she signed it. Interview with the Director on 12/16/24 at 5:03pm revealed: -She did not remember being notified of the duplicate entry for Lantus insulin. -If she had been notified, she would have called the pharmacy to have one of the entries removed. -She could not remove the duplicate entry from the eMAR. Telephone interview with the Administrator on 12/17/24 at 2:53pm revealed when there was a duplicate entry on the eMAR, the MA should notify the Director so one of the entries could be	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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{D 367}	Continued From page 248 removed. d. Review of Resident #5's current FL-2 dated 09/21/24 revealed there was an order for furosemide 20mg (a diuretic used to manage congested heart failure or increased fluid) daily. Review of Resident #5's November 2024 eMAR from revealed: -There was an entry for furosemide 20mg daily with a scheduled administration time of 8:00am. -There was documentation furosemide was administered daily from 11/01/24 to 11/25/24 and from 11/28/24 to 11/30/24. -There were exceptions documented on 11/26/24 and 11/27/24; the exception was the medication was on the eMAR twice. -There was a second entry for furosemide 20mg daily with a scheduled administration time of 8:00am. -There was documentation furosemide 20mg was administered daily from 11/01/24 to 11/22/24 and 11/25/24 to 11/27/24. -There were exceptions documented on 11/23/24, 11/24/24, and from 11/28/24 to 11/30/24; the exceptions were the medication was on the eMAR twice and physically unable to take. Review of Resident #5's December 2024 eMAR from 12/01/24 to 12/10/24 revealed: -There was an entry for furosemide 20mg daily with a scheduled administration time of 8:00am. -There was documentation furosemide was administered daily from 12/01/24 to 12/10/24. -There was a second entry for furosemide 20mg daily with a scheduled administration time of 8:00am. -There was documentation furosemide 20mg was administered daily on 12/02/24, 12/09/24, and on 12/10/24.	{D 367}		

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{D 367}	Continued From page 249 -There were exceptions documented on 12/01/24 and from 12/03/24 to 12/08/24; the exception was physically unable to take. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 12/11/24 at 2:04pm revealed: -The pharmacy did not receive a call that furosemide 20mg daily was on the eMAR twice. -The pharmacy could have removed one of the entries if they had been notified. Interview with a MA on 12/12/24 at 2:41pm revealed: -She notified the Director when a medication was on the eMAR twice. -When a duplicate order was on the eMAR, one should be signed when the medication was administered and the second entry should have an exception documented. -She would document the exception physically unable to take or medication was on the eMAR twice. Interview with another MA on 12/13/24 at 8:06am revealed: -She did not know why there were two entries on the eMAR for the same medication. -She had notified the Director of duplicate entries of the same medication on the resident's eMAR, but the Director did not know how to remove one of the entries. -The Director was going to notify the pharmacy to see if they could remove one of the entries. -She would sign both entries because she did not know what else to do. -She had not been told what to do with the second entry, so she signed it. Interview with the Director on 12/16/24 at 5:03pm	{D 367}		

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{D 367}	Continued From page 250	{D 367}		

revealed:
-She did not remember being notified of the duplicate entry for furosemide.
-If she had been notified, she would have called the pharmacy to have one of the entries removed.
-She could not remove the duplicate entry from the eMAR.

Telephone interview with the Administrator on 12/17/24 at 2:53pm revealed when there was a duplicate entry on the eMAR, the MA should notify the Director so one of the entries could be removed.

3. Review of Resident #6's current FL-2 dated 05/17/24 revealed diagnoses included diabetes mellitus, hypertension and asthma.

a. Review of Resident #6's signed physician orders dated 05/17/24 revealed there was an order for Novolog (a fast-acting insulin used to lower blood sugar) sliding scale insulin (SSI) four times daily as follows: 201 to 250 - 6 units; 251 to 300 - 9 units; 301 to 350 - 12 units; 351 to 400 15 units; greater than 401 call provider.

Review of Resident #6's October 2024 paper medication administration record (MAR) from 10/10/24 to 10/31/24 revealed:
-There was an entry to check blood sugar readings before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm and 7:30pm.
-There was documentation blood sugar checks were done from 10/10/24 to 10/30/24 at 7:30am, 11:30am, 4:30pm and 7:30pm and on 10/31/24 at 7:30am and 11:30am; there were no blood sugar readings documented.
-There was no documentation of blood sugar checks done on 10/31/24 at 4:30pm and 7:30pm.
-There was an entry for Novolog SSI four times

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{D 367}	Continued From page 251 daily as follows: 201 to 250 - 6 units; 251 to 300 - 9 units; 301 to 350 - 12 units; 351 to 400 - 15 units; greater than 401 call provider with a scheduled administration time of 7:30am, 11:30am, 4:30pm and 7:30pm. -There was documentation Novolog SSI was administered from 10/10/24 to 10/30/24 at 7:30am, 11:30am, 4:30pm and 7:30pm; and on 10/31/24 at 7:30am; there was no documentation of the number of units of Novolog administered. -There was no documentation Novolog SSI was administered on 10/31/24 at 11:30am, 4:30pm and 7:30pm; the MAR was blank. Review of Resident #6's November 2024 electronic medication administration record (eMAR) revealed: -There was an entry to check blood sugar readings before meals and at bedtime schedule at 7:30am, 11:30am, 4:30pm and 7:30pm. -There was documentation blood sugar checks were done from 11/01/24 to 11/17/24 and from 11/22/24 to 11/30/24 at 7:30am, 11:30am, 4:30pm and 7:30pm; on 11/18/24 at 7:30am; and on 11/21/24 at 4:30pm and 7:30pm. -There were exceptions documented on 11/18/24 at 11:30am, 4:30pm, and 7:30pm; on 11/19/24 and 11/20/24 at 7:30am, 11:30am, 4:30pm and 7:30pm; and on 11/21/24 at 7:30am and 11:30am; the exception was resident out of facility. -There was an entry for Novolog SSI four times daily as follows: 201 to 250 - 6 units; 251 to 300 - 9 units; 301 to 350 - 12 units; 351 to 400 - 15 units; greater than 401 call provider with a scheduled administration time of 7:30am, 11:30am, 4:30pm and 7:30pm. -There was documentation Novolog SSI insulin was administered 11/02/24 to 11/17/24 and from 11/22/24 to 11/30/24 at 7:30am, 11:30am, 4:30pm	{D 367}		

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{D 367}	Continued From page 252	{D 367}		

and 7:30pm; on 11/01/24 at 7:30am, 11:30am, and 4:30pm; on 11/18/24 at 7:30am; and on 11/21/24 at 4:30pm and 7:30pm; there was no documentation of the number of units of Novolog administered.
-There were exceptions documented on 11/01/24 at 7:30pm; on 11/18/24 at 11:30am, 4:30pm, and 7:30pm; on 11/19/24 and 11/20/24 at 7:30am, 11:30am, 4:30pm and 7:30pm; and on 11/21/24 at 7:30am and 11:30am; the exceptions were resident refused and resident out of facility.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 12/11/24 at 2:04pm revealed:
-The pharmacy did not enter a place for the units of SSI to be documented onto the MAR.
-The facility used paper MARs in October 2024 and the facility staff could hand write on the MAR a place to record the number of units administered to the resident.
-The pharmacy did not enter a place for the units of SSI to be documented onto the November 2024 eMAR; the data would not transfer to the eMAR screen.
-The facility had the ability to enter a place on the November eMAR for the number of units to be documented.

Interview with a medication aide (MA) on 12/12/24 at 2:41pm revealed:
-She documented the number of units of insulin the resident was administered for elevated blood sugar readings in a personal small notebook.
-She left the notebook at the facility, but she had not been able to locate the notebook.
-She did not document the blood sugar readings on the back of the October 2024 MAR.
-She did not notify the Director that there was no where on the November 2024 eMAR to document

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{D 367}	Continued From page 253 the number of units administered. Interview with the Supervisor on 12/12/24 at 3:52pm revealed: -The number of units administered for a SSI order should be documented on the October 2024 paper MAR and the November 2024 eMAR. -There was room on the back of the October 2024 paper MAR to document the number of units of insulin administered or the MAs could right it in on the front of the paper MAR. -The MAs should have told the Director there was no where to document the number of units of insulin administered on the November 2024 eMAR. Interview with the Director on 12/16/24 at 5:03pm revealed: -The MAs should have documented the number of units administered with the SSI order on the back of the October 2024 paper MAR. -The MAs could have written it in on the front of the paper MAR. -She did not know the MAs were not documenting the number of units of insulin that was being administered based on SSI order. -She had not been notified there was no place to document the number of units of insulin administered. -She could have added a place on the eMAR for the MAs to document the number of units of insulin administered. Telephone interview with the Administrator on 12/17/24 at 2:53pm revealed: -The number of units of insulin administered for a SSI should be documented on the MAR/eMAR. -The MAs should have notified the Director there was no where to document the number of units administered on the MAR/eMAR so the Director	{D 367}		

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{D 367}	Continued From page 254 could add a place to document on the MAR/eMAR. b. Review of Resident #6's signed physician orders dated 05/17/24 revealed there was an order for metoprolol tartrate 50mg (used to treat elevated blood pressure) twice daily. Review of Resident #6's October 2024 MAR from 10/10/24 to 10/31/24 revealed: -There was an entry for metoprolol tartrate 50mg twice daily with a scheduled administration time of 9:00am and 9:00pm. -There was documentation metoprolol tartrate was administered from 10/10/24 to 10/31/24 at 9:00am. -There was no documentation metoprolol tartrate was administered from 10/10/24 to 10/31/24 at 9:00pm; the MAR was blank. Telephone interview with a MA on 12/17/24 at 11:15am revealed: -She administered Resident #6's metoprolol each night. -She forgot to document the administration of the medication. -She did not realize she forgot to sign the paper MAR. Interview with the Director on 12/16/24 at 5:03pm revealed: -The MAs should sign the MAR immediately after administration of the medication. -The MARs should be correct when the PCP reviewed the MAR, so the PCP would know how to adjust medications. Telephone interview with the Administrator on 12/17/24 at 2:53pm revealed: -The MAs should document administration of all	{D 367}		

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medications.
-They should verify that all medications administered had been signed off on the eMAR.

c. Review of Resident #6's signed physician orders dated 05/17/24 revealed there was an order for Advair 250-50 Diskus (used to treat asthma and reduce the number of flare-ups) inhale one puff twice daily.

Review of Resident #6's November 2024 eMAR revealed:
-There was an entry for Advair 250-50 Diskus inhale one puff twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Advair was administered from 11/01/24 to 11/17/24 and from 11/22/24 to 11/30/24 at 8:00am and 8:00pm; 11/18/24 at 8:00am; and 11/21/24 at 8:00pm.
-There were exceptions on 11/18/24 at 8:00pm; 11/19/24 and 11/20/24 at 8:00am and 8:00pm; and 11/21/24 at 8:00am; the exception was resident was out of the facility.
-There was a second entry for Advair 250-50 Diskus inhale one puff twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Advair was administered 11/01/24, 11/02/24, 11/05/24, 11/11/24, and 11/12/24, and 11/25/24 at 8:00am and 8:00pm; 11/03/24 at 8:00am; and 11/04/24, from 11/06/24 to 11/08/24, from 11/14/24 to 11/17/24, 11/21/24, from 11/23/24 to 11/27/24, 11/29/24 and 11/30/24 at 8:00pm.
-There were exceptions documented on 11/09/24, 11/10/24, 11/13/24, from 11/18/24 to 11/20/24, 11/22/24, and 11/28/24 at 8:00am and 8:00pm; 11/04/24, from 11/06/24 to 11/08/24, from 11/14/24 to 11/17/24, and 11/19/24 at 8:00am; and 11/03/24 at 8:00pm; the exception was

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{D 367}	Continued From page 256 physically unable to take. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 12/11/24 at 2:04pm revealed: -The pharmacy did not receive a call that Advair 250-50 Diskus was on the eMAR twice. -The pharmacy could have removed one of the entries if they had been notified. Interview with a MA on 12/12/24 at 2:41pm revealed: -She notified the Director when a medication was on the eMAR twice. -When a duplicate order was on the eMAR, one should be signed when the medication was administered and the second entry should have an exception documented. -She would document the exception physically unable to take or medication was on the eMAR twice. Interview with another MA on 12/13/24 at 8:06am revealed: -She did not know why there were two entries on the MAR for the same medication. -She had notified the Director of duplicate entries on the same medication on the residents MAR, but the Director did not know how to remove one of the entries. -The Director was going to notify the pharmacy to see if they could remove one of the entries. -She would sign both entries because she did not know what else to do. -She had not been told what to do with the second entry, so she signed it. Interview with the Director on 12/16/24 at 5:03pm revealed: -She did not remember being notified of the	{D 367}		

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duplicate entry for the Advair inhaler.
-If she had been notified, she would have called the pharmacy to have one of the entries removed.
-She could not remove the duplicate entry from the eMAR.

Telephone interview with the Administrator on 12/17/24 at 2:53pm revealed when there was a duplicate entry on the eMAR, the MA should notify the Director so one of the entries could be removed.

4. Review of Resident #7's current FL-2 dated 07/27/24 revealed diagnoses included schizoaffective disorder, diabetes mellitus type 2, chronic pain, and migraines.

a. Review of Resident #7's signed physician's order dated 07/27/24 revealed there was an order for clonazepam 1mg (used to treat involuntary movements) twice daily.

Review of Resident #7's October 2024 medication administration record (MAR) from 10/10/24 to 10/31/24 revealed:
-There was an entry for clonazepam 1mg twice daily with a scheduled administration time of 8:00am and 4:00pm.
-There was documentation clonazepam was administer from 10/10/24 to 10/31/24 at 8:00am.
-There was no documentation clonazepam was administered from 10/10/24 to 10/31/24 at 4:00pm.

Interview with the a medication aide (MA) on 12/13/24 at 10:20am revealed:
-She gave Resident #7 her clonazepam each night and forgot to sign the paper MAR.
-She always gave Resident #7 her clonazepam.
-She did not realize she forgot to sign the paper

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{D 367}	Continued From page 258 MAR. Interview with the Director on 12/16/24 at 5:03pm revealed: -The MAs should sign the MAR immediately after administration of the medication. -The MARs should be correct so when the primary care provider (PCP) reviewed the MAR, the PCP would know how to adjust medications. Telephone interview with the Administrator on 12/17/24 at 2:53pm revealed: -The MAs should document administration of all medications. -They should verify that all medications administered had been signed off on the eMAR. b. Review of Resident #7's signed physician's order dated 07/27/24 revealed there was an order for rosuvastatin calcium 10mg (used to lower cholesterol) daily. Review of Resident #7's November 2024 eMAR revealed: -There was an entry for rosuvastatin calcium 10mg daily with a scheduled administration time of 8:00am. -There was documentation rosuvastatin was administered daily at 8:00am from 11/01/24 to 11/30/24. -There was a second entry for rosuvastatin calcium 10mg daily with a scheduled administration time of 9:00am entered on the eMAR on 11/20/24. -There was documentation rosuvastatin was administered daily at 9:00am from 11/21/24 to 11/30/24. Review of Resident #7's December 2024 eMAR from 12/01/24 to 12/10/24 revealed:	{D 367}		

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MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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{D 367}	Continued From page 259 -There was an entry for rosuvastatin calcium 10mg daily with a scheduled administration time of 8:00am. -There was documentation rosuvastatin was administered daily at 8:00am from 12/01/24 to 12/09/24. -There was an exception documented on 12/10/24; the exception was physically unable to take. -There was a second entry for rosuvastatin calcium 10mg daily with a scheduled administration time of 8:00am. -There was documentation rosuvastatin was administered daily at 8:00am from 12/01/24 to 12/10/24. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 12/11/24 at 2:04pm revealed: -The pharmacy did not receive a call that rosuvastatin calcium 10mg was on the eMAR twice. -The pharmacy could have removed one of the entries if they had been notified. Interview with a MA on 12/12/24 at 2:41pm revealed: -She notified the Director when a medication was on the eMAR twice. -When a duplicate order was on the eMAR, one should be signed when the medication was administered and the second entry should have an exception documented. -She would document the exception physically unable to take or medication was on the eMAR twice. Interview with another MA on 12/13/24 at 8:06am revealed: -She did not know why there were two entries on	{D 367}		

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{D 367}	Continued From page 260	{D 367}		

the MAR for the same medication.
-She had notified the Director of duplicate entries for the same medication for the residents MAR, but the Director did not know how to remove one of the entries.
-The Director was going to notify the pharmacy to see if they could remove one of the entries.
-She would sign both entries because she did not know what else to do.
-She had not been told what to do with the second entry, so she signed it.

Interview with the Director on 12/16/24 at 5:03pm revealed:
-She did not remember being notified of the duplicate entry for rosuvastatin.
-If she had been notified, she would have called the pharmacy to have one of the entries removed.
-She could not remove the duplicate entry from the eMAR.

Telephone interview with the Administrator on 12/17/24 at 2:53pm revealed when there was a duplicate entry on the eMAR, the MA should notify the Director so one of the entries could be removed.

5. Review of Resident #8's most recent FL-2 dated 11/08/23 revealed diagnoses included metabolic encephalopathy, asthma, dementia, and muscle weakness.

Review of Resident #8's signed physician order dated 09/04/24 revealed there was an order for diclofenac sodium 1% gel (used to treat topical pain) apply 4 grams to knees three times daily.

Review of Resident #8's October medication administration record (MAR) from 10/10/24 to 10/31/21 revealed:

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{D 367}	Continued From page 261 -There was an entry for diclofenac sodium 1% gel apply 4 grams to knees three times daily with a scheduled application time of 9:00am, 3:00pm, and 9:00pm. -There was documentation diclofenac sodium gel was applied from 10/10/24 to 10/30/24 at 9:00pm. -There was no documentation diclofenac sodium gel was applied from 10/10/24 to 10/30/24 at 9:00am and 3:00pm; and on 10/31/24 at 9:00am, 3:00pm, and 9:00pm; the MAR was blank. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 12/11/24 at 2:04pm revealed: -The pharmacy was not notified that diclofenac sodium gel was on the MAR twice. -The pharmacy could have removed one of the entries if they had been notified. Interview with a medication aide (MA) on 12/12/24 at 2:41pm revealed: -She notified the Director when a medication was on the MAR twice. -When a duplicate order was on the MAR, one should be signed when the medication was administered and the second entry should have an exception documented. -She would document exceptions as physically unable to take or medication was on the MAR twice. Interview with another MA on 12/13/24 at 8:06am revealed: -She did not know why there were two entries on the MAR for the same medication. -She had notified the Director of duplicate entries for the same medication on the resident's MAR, but the Director did not know how to remove one of the entries. -The Director was going to notify the pharmacy to	{D 367}		

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{D 367}	Continued From page 262 see if they could remove one of the entries. -She would sign both entries because she did not know what else to do. -She had not been told what to do with the second entry, so she signed it. Interview with the Director on 12/16/24 at 5:03pm revealed: -She did not remember being notified of the duplicate entry for diclofenac sodium gel. -If she had been notified, she would have called the pharmacy to have one of the entries removed. -She could not remove the duplicate entry from the MAR. -On the October 2024 paper MAR, the diclofenac entry could be marked through and hand-written duplicate entry. Telephone interview with the Administrator on 12/17/24 at 2:53pm revealed when there was a duplicate entry on the MAR, the MA should notify the Director so one of the entries could be removed. 6. Review of Resident #9's current FL-2 dated 03/18/24 revealed diagnoses included chronic obstructive pulmonary disease, hypertension, and schizophrenia. Review of Resident #9's signed physician's order dated 03/18/24 revealed there was an order for melatonin 5mg (used to treat insomnia) at bedtime. Review of Resident #9's December 2024 electronic medication administration record (eMAR) from 12/01/24 to 12/09/24 revealed: -There was an entry for melatonin 5mg at bedtime with a scheduled administration time of 9:00pm	{D 367}		

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{D 367}	Continued From page 263 -There was documentation melatonin 5mg was administered at bedtime from 12/01/24 to 12/09/24. -There was a second entry for melatonin 5mg at bedtime with a scheduled administration time of 9:00pm. -There was documentation melatonin 5mg was administered at bedtime from 12/01/24 to 12/06/24 and on 12/09/24. -There were exceptions documented on 12/07/24 and 12/08/24; the exceptions were physically unable to take and medication was on the MAR twice. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 12/11/24 at 2:04pm revealed: -The pharmacy did not receive a call that melatonin 5mg was on the eMAR twice. -The pharmacy could have removed one of the entries if they had been notified. Interview with a medication aide (MA) on 12/12/24 at 2:41pm revealed: -She notified the Director when a medication was on the eMAR twice. -When a duplicate order was on the eMAR, one should be signed when the medication was administered and the second entry should have an exception documented. -She documented the exceptions as physically unable to take or medication was on the eMAR twice. Interview with another MA on 12/13/24 at 8:06am revealed: -She did not know why there were two entries on the eMAR for the same medication. -She had notified the Director of duplicate entries of the same medication on the resident's eMAR,	{D 367}		

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{D 367}	Continued From page 264 but the Director did not know how to remove one of the entries. -The Director was going to notify the pharmacy to see if they could remove one of the entries. -She would sign both entries because she did not know what else to do. -She had not been told what to do with the second entry, so she signed it. Interview with the Director on 12/16/24 at 5:03pm revealed: -She did not remember being notified of the duplicate entry for melatonin. -If she had been notified, she would have called the pharmacy to have one of the entries removed. -She could not remove the duplicate entry from the eMAR. Telephone interview with the Administrator on 12/17/24 at 2:53pm revealed when there was a duplicate entry on the eMAR, the MA should notify the Director so one of the entries could be removed. 8. Review of Resident #2's current FL-2 dated 09/10/24 revealed diagnoses included hypertension and peripheral artery disease. Review of Resident #2's signed physician's order dated 10/29/24 revealed an order for Tramadol HCL (used to treat moderate to severe pain) 100mg take one tablet every 12 hours as needed (PRN). Review of Resident #2's October 2024 paper medication administration record (MAR) revealed: -There was a handwritten entry for Tramadol HCL 100mg take one tablet every 12 hours as needed.	{D 367}		

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{D 367}	Continued From page 265 -There was no documentation Tramadol HCL 100mg was administered from 10/29/24-10/31/24. Review of Resident #2's November 2024 electronic MAR (eMAR) revealed: -There was an entry for Tramadol HCL 100mg take one tablet every 12 hours as needed. -There was no documentation Tramadol HCL 100mg was administered from 11/01/24-11/30/24. Review of Resident #2's controlled substance count sheets (CSCS) revealed: -The CSCS was for 20 tablets of Tramadol HCL 100mg with a dispensed date of 10/29/24. -There was documentation Resident #2's Tramadol was signed out on 10/30/24 and 10/31/24. -There was documentation Resident #2's Tramadol was signed out on 11/01/24, 11/07/24, 11/08/24, 11/10/24, 11/11/24, 11/14/24, 11/15/ 24, 11/17/24, and 11/18/24. -Tramadol was documented as signed out 11 times and the count was 9 tablets of Tramadol HCL 100mg were remaining. Observation of Resident #2's medications on hand on 12/10/24 at 11:55am revealed a punch card of Tramadol HCL 100mg dispensed on 10/29/24 with 9 of 20 tablets remaining. Interview with a medication aide (MA) on 12/13/24 at 9:04am revealed: -When PRN medications were administered, she documented C. -When she administered Resident #2's controlled medication, she documented on the CSCS but forgot to document it on the MAR. Interview with another MA on 12/16/24 at	{D 367}		

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{D 367}	Continued From page 266 11:00am revealed: -She was supposed to document on the MAR or eMAR when controlled medication was administered. -She knew she documented on the CSCS. -She probably "just forgot" to document on the MAR or eMAR. Interview with the Director on 12/16/24 at 3:11pm revealed: -Staff were to document the administration of controlled medications on the CSCS as well as the eMAR. -When the PRNs were documented on the eMAR, the MA had to document why the PRN was being administered. -The MA would then have to document one hour later the effectiveness of the medication. -She was concerned if the PRN was not documented on the MAR, the medication could be administered too close together. Interview with the Administrator on 12/16/24 at 5:49pm revealed: -Medications that were administered should be documented on the eMAR. -The MA should also document the effectiveness of the medication on the eMAR. -Controlled medications signed out should be documented on the eMAR and the CSCS. 7. Review of Resident #3's most recent FL-2 dated 11/06/23 revealed diagnoses included diabetes mellitus type 2, and hypertension. Review of Resident #3's current FL-2 dated 11/06/23 revealed: -There was an order for sliding scale insulin (SSI) four times daily based on finger stick blood sugar (FSBS) results.	{D 367}		

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{D 367}	Continued From page 267 -The order was fast-acting aspart insulin (FIAsp) (used to treat diabetes) 100 units/1ml before meals and at bedtime per SSI; 150-200 =20 units, 201-250=22 units, 251-300=24 units, 301-350=27 units, 351-400=30 units, 401-450=33 units. Review of Resident #3's MAR for October 2024 revealed: -There was an entry for SSI based on FSBS results scheduled at 7:30am, 11:30am, 4:30am and 8:00pm. -The entry was documented as completed four times daily but there were no amounts of insulin administered documented per the SSI order. Interview with Resident #3 on 12/11/24 at 11:45am revealed: -He had his "finger stuck all day long to check his sugar"; the MAs checked his sugar with meals and at bedtime. -They used to forget to check him, but they did it all the time now. -Sometimes he got a shot after the MA "stuck" his finger. Interview with a medication aide (MA) on 12/13/24 at 9:25am revealed: -There was nowhere to document the amount of insulin she would administer per his SSI on the MAR. -Resident #3's insulin injections per his SSI were not documented on the MAR in October 2024 because there was nowhere to document them. -She would write the amount of insulin injected on a piece of paper and place it in a book; the next day the paper was gone. -She told the Director in October 2024 there was nowhere to document the SSI dose. -The Director asked the pharmacy for something to document on but the they never sent anything.	{D 367}		

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{D 367}	Continued From page 268 Interview with the Director on 12/10/24 at 4:20pm revealed: -The MAs were supposed to document the amount of insulin administered to Resident #3 based on the SSI on the back of the MAR. -She was sure the SSI was administered as ordered because Resident #3 had an order for FSBS before administering insulin, but the MA just did not document the results. -She told the MAs to write the amount of insulin administered on the back of the MAR to show proof they were complete. -She did not know why the MAs did document the amounts of insulin administered. -She had not reviewed the October 2024 MARs; she thought the MAs were doing what they were supposed to be doing. Telephone interview with the Administrator on 12/17/24 at 2:53pm. -The number of units of insulin administered for a SSI should be documented on the MAR. -The MAs could document on the front or the back of the paper MAR and could have the Director to add it on the MAR.	{D 367}		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration.	D 378		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications left on top of a medication cart were locked when not under the direct physical supervision of a medication aide.

The findings are:

Review of the facility's medication administration policy dated 06/2023 revealed the facility staff should not leave medications unattended.

Observation of a medication aide (MA) administering medications on 12/10/24 between 8:12am and 8:17am revealed:
-The MA positioned the medication cart at the room door of a resident.
-The MA prepared 3 pills for administration by popping them from a bubble pack into a souffle cup.
-The MA placed the 3 bubble packs on top of the medication cart after preparing the medications.
-The MA left the medication cart and entered the resident's room to administer the medication.
-The 3 bubble packs remained on top of the medication cart.
-The resident was in bed; the MA turned her back to the medication cart, assisted the resident to a sitting position, and administered the medications.
-The MA realized the 3 bubble packs of medication were on top of the medication cart when she returned; she placed the medication in the medication cart, and locked the medication cart.

Interview with the MA on 12/10/24 at 1:14pm revealed:
-She knew she was not to leave medications on

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D 378	Continued From page 270 top of the medication cart when she walked away. -She should have placed the medications in the locked medication cart before walking in the residents room. -She made a mistake; she thought she had locked the medications in the medication cart. Interview with the Director on 12/16/24 at 5:03pm revealed: -All medications should be locked in the medication cart when the MA was not at the medication cart. -A resident could walk by the medication cart and pick up the medications lying on top of the medication cart; the resident could take the medication and become sick. -She expected the MAs to keep all medications secure by locking them in the medication cart. Interview with the Administrator on 12/17/24 at 10:33am revealed: -Medication should be locked in the medication cart after the medication has been prepared to be administered. -Anyone of the residents could have walked by and picked up the medications. -He was concerned that another resident could consume the medications. -He expected the MA to keep all medications locked in the medication cart when the MA was not standing at the medication cart.	D 378		
D 419	10A NCAC 13F .1104 (a) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (a) To document a resident's receipt of the State-County Special Assistance personal needs	D 419		

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allowance after payment of the cost of care, a statement shall be signed by the resident or marked by the resident. If the statement is marked by the resident, there shall be one witness signature. For residents who have been adjudicated incompetent, the signature of the resident's authorized representative shall be required. Witnesses cannot include the staff handling the residents' personal funds transactions. The statement shall be maintained in the facility.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to document a resident's receipt of the personal needs allowance after payment of the cost of care with a statement being signed by the resident or marked by the resident with a witness's signature for 4 of 4 sampled residents (#3, #6, #9, #14).

The findings are:

1. Review of Resident #3's current FL-2 dated 11/06/23 revealed diagnoses included schizophrenia, mild retardation, diabetes mellitus type 2, and hypertension.

Review of Resident #3's Account Ledger Sheet dated October 2024 through November 2024 revealed:
-There was an entry on 10/01/24, Resident #3's room and board of $1326.00 were deducted

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	HAL073010	A. BUILDING: _____ B. WING _____	R 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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leaving a balance of $603.39.
-There was a second entry on 10/01/24, Resident #3 had a total of $1417.00 deposited leaving a balance of $2020.39.
-On 10/27/24, Resident #4's September 2024 pharmacy bill for $129.00 was paid, leaving a balance of $1891.39.
-There was no documentation that Resident #3 received any monies in October 2024.
-There was an entry on 11/01/24, Resident #3's room and board of $1326.00 were deducted leaving a balance of $565.39.
-There was a second entry on 11/01/24, Resident #3's had a credit of $1371.00.
-There was an entry on 11/03/24, Resident #3's had a credit of $46.00.
-On 11/20/24, Resident #4's October 2024 pharmacy bill for $62.17 was paid, leaving a balance of $1920.22
-There was an entry on 11/21/24, Resident #3 received $27.83 leaving a balance of $1892.39; there was no resident signature.
-The only signatures for any monies deducted was the Director's signature.

Review of a copy of Resident #3's referenced check numbers revealed:
-Check #5706 was dated 10/17/24 for $129.00 paid to the pharmacy for Resident #3's September 2024 pharmacy bill.
-Check #5738 was dated 11/13/24 for $62.17 paid to the pharmacy for Resident #3's pharmacy bill.
-Check #5754 was dated 11/21/24 for $27.83 paid to cash for Resident #3.

Interview with Resident #3 on 12/12/24 at 9:00am revealed:
-The Director had not given him any spending money from his resident account.

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D 419	Continued From page 273 -He needed money. Interview with the Director on 12/12/24 at 8:50am revealed: -She gave Resident #3 $27.83 cash on 11/21/24. -She did not have anything to show Resident #3 was given $27.83. -She did not get Resident #3 to sign for the $27.83. -She did not know she was supposed to. Refer to the interview with the Director on 12/16/24 at 3:11pm. Refer to the interview with the Administrator on 12/16/24 at 5:49pm. 2. Review of Resident #6's current FL-2 dated 05/17/24. Review of the Account Ledger Sheet for Resident #6 dated September 2024 through November 2024 revealed: -There was an entry on 09/01/24, Resident #6 had a starting total of $1589.18. -On 09/01/24, Resident #6 had a deposit of $473.00 for a total of $2062.18. -On 10/22/24, Resident #6 was paid $90.00, reference check #5721 for August 2024 and another $90.00, reference check #5722 for September 2024 leaving a balance of $1882.18. -On 11/01/24, Resident #6's room and board of $1326.00 was deducted leaving a balance of $556.18. -There was a second entry on 11/01/24, Resident #6 had a credit of $943.00 leaving a balance of $1499.18. -There was an entry on 11/03/24, Resident #6 had a credit of $473.00 leaving a balance of $1972.18.	D 419		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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-On 11/20/24, Resident #6 was paid $90.00, leaving a balance of $1882.18.
-The only signatures for any monies deducted was the Director's signature.

Review of a copy of Resident #6's referenced check numbers revealed:
-Check #5721, was for $90.00 cash, dated 10/22/24, and was for Resident #6.
-Check #5722, was for $90.00 cash, dated 10/22/24, and was for Resident #6.
-Check #5757, was for $90.00 cash, dated 11/21/24, and was for Resident #6.

Interview with Resident #6 on 12/13/24 at 8:37am revealed:
-He was given a check every month to sign but he did not know how much the check was for.
-The staff member did not show him the front of the check.
-He was given $60.00 last month.
-He gave his money to a staff member to buy him things he needed, and she brought his change back with a receipt; he did not have a copy of the receipt.
-He used to sign a sheet of paper when he was given his money, but he had not signed for the money "in a while."
-Sometimes he was given $40.00, $50.00, or $60.00 and he did not get any more than that and "guessed the rest went to the facility for food or something."

Refer to the interview with the Director on 12/16/24 at 3:11pm.

Refer to the interview with the Administrator on 12/16/24 at 5:49pm.

3. Review of Resident #9's current FL-2 dated

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D 419	Continued From page 275 3/18/24 revealed diagnosis included chronic obstructive pulmonary disease (COPD). Review of the Account Ledger Sheet for Resident #9 dated October 2024 through November 2024 revealed: -Resident #9 had a negative balance of $3343.82 on 10/01/24. -There was an entry on 10/01/24, Resident #9 had a debit of $1326.00 for room and board leaving a negative balance of $4669.82. -There was a second entry on 10/01/24 that Resident #9 was credited $1416.00 from social security leaving a negative balance of $3253.82. -There was an entry on 10/25/24, Resident #9 had a debit of $7.07 for his September 2024 pharmacy bill leaving a negative balance of $3343.82. -There was an entry on 11/01/24, Resident #9 had a debit of $1326.00 for November 2024 room and board leaving a negative balance of $4669.82 -On 11/01/24, Resident #9 had a credit of $1224.00, leaving a negative balance of $3445.82. -On 11/03/24, Resident #9 had a credit of $192.00, leaving a negative balance of #3253.82. -On 11/10/24, Resident #9 had a debit of $18.31 for his October Pharmacy bill leaving a negative balance of $3272.13. -On 11/21/24, Resident #9 had a debit of $71.69, there was no other information documented. -There were no other entries. -The only signatures for any monies deducted was the Director's signature. Review of Resident #9's pharmacy bills revealed: -Resident #9's October 2024 pharmacy bill was $7.07. -Resident #9's November 2024 pharmacy bill was	D 419		

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D 419	Continued From page 276 $18.31. Review of a copy of Resident #9's referenced check numbers revealed: -Check #5716 was dated 10/17/24 for $7.07, paid to the pharmacy for Resident #9. -No other checks were available to be reviewed for Resident #9. Interview with Resident #9 on 12/13/24 at 9:43am revealed: -He was given money to spend every month. -He did not know how much money he was given. -He did not sign anything; the Director just gave him the money. Refer to the interview with the Director on 12/16/24 at 3:11pm. Refer to the interview with the Administrator on 12/16/24 at 5:49pm. 4. Review of Resident #14's current FL-2 dated 07/19/24 revealed diagnoses included hypertension, cerebral infarction, and gout. Review of the Account Ledger Sheet for Resident #14 dated October 2024 through November 2024 revealed: -There was an entry on 10/01/24, Resident #14 had a negative balance of $1671.41. -There was a second entry on 10/01/24 that Resident #14 was credited $1225.00 leaving a negative balance of $446.41. -There was an entry on 10/25/24 for a debit of $20.97 for the September 2024 pharmacy bill leaving a negative balance of $467.38. -There was a second entry on 10/25/24 for a debit of $69.03, leaving a negative balance of $536.41.	D 419		

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D 419	Continued From page 277 -There was entry on 11/01/24 for a debit of $1326.00 for November room and board leaving a negative balance of $1862.41. -There was a second entry on 11/01/24 for a credit of $963.00 leaving a negative balance of $899.41. -There was an entry on 11/03/24 for a credit of $454.00 leaving a negative balance of $445.41. -On 11/20/224, there was a debit of $39.24 for Resident #14's October pharmacy bill leaving a negative balance of $484.65. -On 11/21/24, there was a debit of $51.76 for Resident #14 leaving a negative balance of $536.41. -The only signatures for any monies deducted was the Director's signature. Review of a copy of Resident #14's referenced check numbers revealed: -Check #5713, dated 10/17/24 for $20.97, paid to the pharmacy for Resident #14. -Check #5752, dated 11/21/24 for $51.76, paid to cash for Resident #14. -There were no other checks available for review for Resident #14. Interview with Resident #14 on 12/13/24 at 8:48am revealed: -He usually received "about" $50.00 each month. -A couple of months ago, he was only given $30.00, and he went to the office to find out why. -He was told he had a medicine bill, but he did not see the bill. -He signed his check every month, but he did not see the amount of the check he signed. Refer to the interview with the Director on 12/16/24 at 3:11pm. Refer to the interview with the Administrator on	D 419		

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D 419	Continued From page 278 12/16/24 at 5:49pm. _____ Interview with the Director on 12/16/24 at 3:11pm revealed: -The residents' direct deposits came in at different times, some came in on the first and third of the month, and others came in the middle and end of the month. -The pharmacy usually billed the residents by the sixth of the month. -She waited until all the direct deposits were in and pharmacy bills were deducted before giving the residents their monthly funds. -She waited to do all the residents' monthly funds at one time to make sure she did not miss anyone. -She knew she was supposed to have the residents sign for their monthly funds. -The residents no longer had to sign the back of the checks because the bank told her to make the checks out to cash. -She and the Administrator were the only staff who handled residents' funds. -The bank teller put the cashed checks directly into an individual packet with the resident's name. -The packet was then given directly to the resident. -The resident did not open and verify the amount of money in the packet. -She had some residents who came to her and asked why they did not get $90.00 each month and she would show them the pharmacy bill. Interview with the Administrator on 12/16/24 at 5:49pm revealed: -He expected the Director to explain to each resident what their copay was at the pharmacy and sign for any money they received. -Monies received by the resident should always have the resident's signature and should also	D 419		

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D 419	Continued From page 279 have a staff member's signature verifying the amount that was given to the resident. -He knew monies distributed should be within 24 hours of the resident's money being deposited, but the facility did not receive the pharmacy bill in a timely manner. -If one resident received their monthly money and another resident did not it would cause a problem with the residents, so it would be better to pay all the residents at the same time.	D 419		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to complete Health Care Personnel Registry (HCPR) reports for alleged verbal and physical abuse by Staff B, Staff C, and Staff D toward multiple residents who were hit, cursed at, and sprayed with water. The findings are: Review of the facility's Abuse, Neglect, and Resident Care undated policy revealed: -All residents and visitors should be treated with kindness, friendliness, patience, and respect. -Employees should refrain from gossip, loud talking unnecessary noise, and forms of	D 438		

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misconduct that could disturb residents and distract from the professionalism of the facility and its staff.
-The facility maintained a zero-tolerance policy for any type of abuse or neglect of any resident.
-If accusations occurred, they would be reported to the HCPR registry within 24 hours.

Confidential interview with a resident revealed:
-The resident observed another resident being hit on "all the time."
-The resident did not recall the last time the staff hit the other resident, but it happened all the time.
-The resident had observed staff hit the resident in the face and "anywhere they could."
-Sometimes the staff was good and sometimes the staff was bad.
-Staff were bad because they pulled on residents and would "snatch" residents by the arm.
-When the staff wanted the resident "to come on" they would pull on the resident.
-The resident had water thrown in their face before.
-The resident had been "pushed out" of the dining room.
-The staff cursed the residents all the time.

Confidential telephone interview with a resident's family member revealed:
-She had heard staff curse the residents.
-She had heard "all of the staff" curse the residents.
-She had heard the staff tell a resident, "I will whoop you [expletive].
-She had heard the staff tell a resident to get in there and sit your [expletive] down.
-She had heard the staff tell a resident you are not getting [expletive].

Interview with a resident on 12/10/24 at 8:44am

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D 438	Continued From page 281 revealed: -He had seen multiple staff members punch a [named] resident in the face; he saw it last month. -He had seen multiple staff members hit a second [named] resident, most recently last month. -Staff members cursed "him out." -Staff B and Staff D cursed at the residents. -The staff members would tell the residents every day to "shut the [expletive] up." Interview with a second resident on 12/10/24 at 9:10am revealed: -He had seen staff members hit a [named] resident. -He had seen staff hit a second [named] resident. -Sometimes staff squirted the residents with water. -The squirt bottle was used to make "us not say bad things." -One of the staff was a medication aide (MA) and the other was a cook. -The staff members would say they are going to knock the [expletive] out of you. -The staff members had told him they were going to knock him silly, and they were going to knock him into next week. Interview with a third resident on 12/10/24 at 11:37am revealed: -He had seen staff grab a [named] resident and drag the resident across the floor. -This happened in the living room about 3-4 weeks ago. -He had seen staff hit a second [named] resident with a stick and a ruler. -Staff cursed the residents all the time. -He had seen the medication aides (MA) and the cook curse the residents. -Staff squirted residents with water if the resident was talking when the staff had told the resident to	D 438		

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D 438	Continued From page 282 be quiet. Interview with a fourth resident on 12/10/24 at 11:45am revealed: -He had seen staff squirt water on a [named] resident. -He saw staff hit a second [named] resident yesterday, 12/09/24. -Staff cursed at the resident. -Two days ago, he saw a staff member hit the resident with a ruler; he did not name the staff member. -Staff members were cursing the residents yesterday. -When asked which staff he stated, "All of them." -He had seen staff squirt water on residents. Interview with a fifth resident on 12//10/24 at 1:21pm revealed: -He had seen staff members hit a [named] resident. -He had seen Staff B hit a second [named] resident. -He had not seen the resident do anything, so he did not know why the cook hit the resident. -He saw Staff C hit the second [named] resident with a ruler. Interview with a sixth resident on 12//10/24 at 1:31pm revealed he had seen staff members hit a second [named] resident. Interview with Staff B on 12/12/24 at 4:24pm revealed: -She had not heard any staff curse the residents, hit a resident, or squirt water on a resident. -She had not cursed a resident, hit a resident, or squirted water on a resident. Interview with the Staff C on 12/10/24 at 4:34pm	D 438		

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D 438	Continued From page 283 revealed: -She had not seen any staff curse at residents, hit residents, hit residents with a ruler/stick, or spray water on residents. -She had not heard any residents complain that they had been cursed, hit, or sprayed with water. -She had not cursed any residents, hit a resident or sprayed water on a resident. Interview with Staff D on 12/13/24 at 9:04am revealed: -She had never seen staff raise their voices at residents, curse residents, or hit residents. -She had not heard any resident complain that anyone had done these things. Interview with the Director on 12/13/24 at 2:17pm revealed: -She had not completed a HCPR 24-hour report on the staff names given to her, (Staff B, Staff C, Staff D). -She did not know she needed to complete a HCPR 24-hour report. -She thought a HCPR report only had to be done if an injury was visible. Telephone interview with the Administrator on 12/13/24 at 2:31pm revealed: -The Director was responsible for completing the 24-hour report. -A 24-hour report would be completed if there was reason to believe a resident was mistreated or abused. -He had not heard of the allegations until the Director told him. -If there was anything like this going on, the residents would tell him or the Director. -It would be unacceptable if the allegations were true. _____	D 438		

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D 438	Continued From page 284 The facility's failed to report allegations of physical and verbal abuse to the HCPR within 24 hours of the notification of the allegations to the Director on 12/10/24 regarding allegations of cursing, hitting, and spraying water at residents involving Staff B, Staff C, and Staff D. This failure resulted in putting the residents at risk of verbal and physical harm which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/13/24. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2025.	D 438		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to notify the County Department of Social Services (DSS) of an incident/accident that required emergency medical evaluation for 2 of 2	D 451		

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MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 451	Continued From page 285	D 451		

residents (#1 and #7) who had multiple falls with injury (#1) and a laceration caused by a fall (#7).

The findings are:

1. Review of Resident #1's current FL-2 dated 11/05/24 revealed:
-Diagnoses included multiple falls, gait instability, diabetes mellitus type 2 with hyperglycemia, hypertension, and hyperlipidemia.
-He was semi-ambulatory

Review of Resident #1's incident/accident report dated 11/24/24 revealed:
-The time of the incident/accident was around 9:45am.
-Resident #1 stood up from eating breakfast, had what seemed to be a seizure, fell backwards and hit his head on the floor
-Emergency Medical Services (EMS) were notified, and Resident #1 was transported to the hospital.
-There was no documentation this incident/accident report had been reported to DSS.

Review of Resident #1's incident/accident report dated 12/07/24 revealed:
-The time of the incident/accident was at 7:15pm.
-Attempted to assist Resident #1 to the shower; he was very weak and had diarrhea.
-Resident was unable to stand to take a shower; he was lowered to the floor and EMS was called.
-There was no documentation this incident/accident report had been reported to DSS.

Review of Resident #1's EMS reports from 10/21/24 to 12/06/24 revealed:
-On 10/21/24, Resident #1 was transported to the

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D 451	Continued From page 286 emergency department (ED) for dizziness with a fall. -On 10/24/24, Resident #1 was transported to the ED for a seizure and a fall. -On 10/25/24, Resident #1 was transported to the ED for a fall with a head injury. -On 10/26/24, Resident #1 was transported to the ED for a fall with a head injury. -On 10/26/24, Resident #1 was transported for the second time to the ED for dizziness with a fall causing a hemorrhage. -On 10/30/24, Resident #1 was transported to the ED for a fall with a head injury. -On 10/31/24, Resident #1 was transported to the ED for a fall with a head injury. -On 11/26/24, Resident #1 was transported to the ED for a fall with a head injury. -On 12/04/24, Resident #1 was transported to the ED for a fall with a head injury. -On 12/06/24, Resident #1 was transported to the ED for altered mental status. Interview with a medication aide (MA) on 12/13/24 at 8:06am revealed: -Resident #1 was sent to the hospital each time he fell and hit his head. -Anyone could do an incident/accident report. -She did not remember completing an incident/accident report for Resident #1. -She would get busy and forget to complete an incident/accident report for Resident #1 each time he fell. Interview with the Supervisor on 12/12/24 at 3:52pm revealed: -She knew of two falls Resident #1 had and was sent to the ED. -She thought incident reports were completed on all the falls with injury.	D 451		

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D 451	Continued From page 287 Interview with the Director on 12/16/24 at 5:03pm revealed: -Resident #1 did not have an incident/accident report completed each time he fell and was sent to the ED. -The MAs would forget to complete an incident/accident report. -Resident #1 had multiple falls. -It was the responsibility of the MA to initiate the incident/accident report. -She did not remember sending any incident/accident reports to DSS for Resident #1. -It was her responsibility to send the completed incident/accident reports to DSS. Refer to the telephone interview with the Adult Home Specialist Supervisor of the county DSS on 12/16/24 at 8:42am. Refer to the interview with the Director on 12/16/24 at 5:03pm. Refer to the interview with the Administrator on 12/17/24 at 10:33am. 2. Review of Resident #7's current FL-2 dated 07/07/24 revealed -Diagnoses included schizoaffective disorder, diabetes mellitus type 2, chronic pain and migraines. -She was ambulatory. Review of Resident #7's Emergency Medical Services (EMS) record dated 11/10/24 revealed: -EMS was dispatched to the facility on 11/10/24 for a fall with injury. -Resident #7 was noted to have a laceration on her face. -Resident #7 was transferred to the local Emergency Department (ED) for treatment.	D 451		

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D 451	Continued From page 288 Review of the facility's incident/accident reports for November 2024 revealed there were no incident/accident reports completed for Resident #7. Interview with a medication aide (MA) on 12/13/24 at 8:08am revealed: -She did not work the day Resident #7 fell. -She returned to work and saw she had sutures on her face. -She did not know if an incident/accident report was completed for Resident #7. Interview with the Director on 12/16/24 at 5:03pm revealed: -Resident #7 did not have an incident/accident report completed when she fell and caused a laceration to her head. -It was the responsibility of the MA to initiate the incident/accident report. -She did not remember sending an incident/accident report to Department of Social Services (DSS) for Resident #7. Refer to the telephone interview with the county DSS Adult Services Supervisor on 12/16/24 at 8:42am. Refer to the interview with the Director on 12/16/24 at 5:03pm. Refer to the interview with the Administrator on 12/17/24 at 10:33am. _____ Telephone interview with the county DSS Adult Services Supervisor on 12/16/24 at 8:42am revealed: -The DSS had not received any incident/accident reports from the facility in the past 6 months.	D 451		

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D 451	Continued From page 289 -Any incident/accident reports including falls with injury should be sent to DSS within 72 hours. Interview with the Director on 12/16/24 at 5:03pm revealed: -An incident/accident report should be completed as soon as the incident/accident happened. -Incident/accident reports should be completed when a resident fell. -She reviewed and signed all the incident/accident reports, and once signed, she filed them. -She did not fax the incident/accident reports to DSS if the resident fell. -She had forgotten to fax the incident/accident reports to DSS. Interview with the Administrator on 12/17/24 at 10:33am revealed: -Incident/accident reports should be completed for all residents when there was a fall with injury and transported to the ED. -The Director was responsible for sending the incident/accident reports to DSS within 24 hours of the incident/accident. -He expected the Director to send the incident/accident reports to DSS within 24 hours.	D 451		
{D 611}	10A NCAC 13F .1801(b) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (b) The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following: (1) Standard and transmission-based precautions, including:	{D 611}		

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{D 611}	Continued From page 290 (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of illness; and use of source control as tolerated by the residents; and (4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak.	{D 611}		

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{D 611}	Continued From page 291 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to follow the Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 4 of 4 sampled diabetic residents (#1, #3, #5 and #6) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. The findings are: Review of the CDC guidelines for infection control revealed: -The CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. -If the glucometer was to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructions. -If the manufacturer did not list disinfection information, the glucometer should not be shared between residents. Review of the manufacturer's manual for Brand A glucometers revealed: -Indirect transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV) during the delivery of healthcare services have been increasingly reported by persons using glucose monitoring systems as a risk group due to	{D 611}		

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{D 611}	Continued From page 292	{D 611}		

sharing of blood glucose meters.
-The Food and Drug Administration's (FDA) Public Health notification revealed the use of a finger-stick device on more than one person posed a risk for transmitting blood-borne pathogens.
-CDC Clinical Reminder: Use of a finger-stick device on more than one person posed a risk for transmitting blood-borne pathogens.

Observation of the facility's south-hall medication cart on 12/10/24 at 11:30am revealed:
-There were four black zippered bags in the top drawer of the medication cart.
-The four black zippered bags were not labeled with a resident's name.
-Each black zippered bag contained a glucometer labeled with a resident's name on the back of each glucometer.

1. Review of Resident #1's current FL-2 dated 11/05/24 revealed:
-Diagnosis included diabetes.
-There was an order to check blood sugar three times daily before meals.

Observation of Resident #1's Brand A glucometer on 12/10/24 at 11:45 revealed there was a black zippered bag with no name that contained a glucometer with Resident #1's name on the back of the glucometer.

Review of Resident #1's Brand A glucometer history revealed the current date in the glucometer was 08/20/24 at 10:01am.

Review of Resident #1's November 2024 electronic administration medication record (eMAR) compared to Resident #1's glucometer history from 11/18/24 to 11/30/24 revealed:

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{D 611}	Continued From page 293 -There was an entry for blood sugar checks before meals and at bedtime with a scheduled time of 7:30am, 11:30am, 4:30pm, and 7:30pm. -There was documentation Resident #3's blood sugar was checked and recorded before meals and bedtime from 11/18/24 to 11/30/24. -On 11/18/24, at 4:30pm, there was documentation of a blood sugar reading of 236 that was not recorded in Resident #1's glucometer. -On 11/18/24, at 11:30am, there was documentation of a blood sugar reading of 193 that was not recorded in Resident #1's glucometer -On 11/18/24, at 7:30am, there was documentation of a blood sugar reading of 103 that was not recorded in Resident #1's glucometer. -On 11/22/24, at 4:30pm, there was documentation of a blood sugar reading of 194 that was not recorded in Resident #1's glucometer; the blood sugar reading of 194 was on another resident's glucometer. -On 11/28/24 at 7:30pm, there was documentation of a blood sugar reading of 155 that was not recorded in Resident #1's glucometer. -On 11/29/24 at 7:30am, there was documentation of a blood sugar reading of 118 that was not recorded in Resident #1's glucometer. -On 11/29/24 at 11:30am, there was documentation of a blood sugar reading of 119 that was not recorded in Resident #1's glucometer. -There were 8 blood sugar readings recorded in Resident #1's glucometer from 11/18/24 to 11/30/24 that were not documented on the eMAR; the blood sugar readings were 388, 331, 376, 386, 409, 425, 465, and 559.	{D 611}		

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{D 611}	Continued From page 294 -On 08/04/24, there was a blood sugar reading of 388 at 1:37pm and 331 at 2:48pm Resident #1's glucometer. -On 08/04/24, there was a blood sugar reading of 376 at 7:30pm and 385 at 7:32pm Resident #1's glucometer. -On 08/06/24, there was a blood sugar reading of 386 at 6:50pm and 340 at 6:58pm Resident #1's glucometer. -On 08/07/24, there was a blood sugar reading of 425 at 1:37pm and 409 at 1:38pm Resident #1's glucometer. Review of Resident #1's December 2024 eMAR compared to Resident #1's glucometer history from 12/02/24 to 12/06/24 revealed: -There was an entry for blood sugar checks before meals and at bedtime with a scheduled time of 7:30am, 11:30am, 4:30pm, and 7:30pm. -There was documentation Resident #1's blood sugar was checked and recorded before meals and bedtime from 12/02/24 to 12/06/24. -On 12/03/24, at 7:30pm, there was documentation of a blood sugar reading of 400 that was not recorded in Resident #1's glucometer. -On 12/04/24, at 4:30pm, there was documentation of a blood sugar reading of 399 that was not recorded in Resident #1's glucometer. -On 12/04/24, at 7:30pm, there was documentation of a blood sugar reading of 300 that was not recorded in Resident #1's glucometer. -On 12/05/24, at 7:30am, there was documentation of a blood sugar reading of 210 that was not recorded in Resident #1's glucometer. -On 12/05/24, at 4:30pm, there was documentation of a blood sugar reading of 311	{D 611}		

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that was not recorded in Resident #1's glucometer.
-On 12/05/24, at 7:30pm, there was documentation of a blood sugar reading of 400 that was not recorded in Resident #1's glucometer.
-On 12/06/24, at 7:30am, there was documentation of a blood sugar reading of 389 that was not recorded in Resident #1's glucometer.
-On 12/06/24, at 11:30pm, there was documentation of a blood sugar reading of 395 that was not recorded in Resident #1's glucometer.
-There were 8 blood sugar readings recorded in Resident #1's glucometer from 12/02/24 to 12/06/24 that were not documented on the eMAR; the blood sugar readings were 546, 413, 487, 500, 304, 426, 587, and 472.
-On 08/17/24, there was a blood sugar reading of 546 at 10:35am and 284 at 10:36am on Resident #1's glucometer.
-On 08/17/24, there was a blood sugar reading of 413 at 2:01pm and 460 at 2:02pm on Resident #1's glucometer.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

Refer to the telephone interview with the primary care provider (PCP) on 12/11/24 at 5:30pm.

Refer to the interview with a medication aide (MA) on 12/12/24 at 2:41pm.

Refer to the interview with a second MA on 12/13/24 at 8:08am.

Refer to the interview with the Supervisor on

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{D 611}	Continued From page 296 12/12/24 at 3:52pm. Refer to the interview with the Director on 12/16/24 at 5:03pm. Refer to the interview with the Administrator on 12/17/24 at 10:33am. 2. Review of Resident #3's current FL-2 dated 11/06/23 revealed diagnosis included diabetes mellitus type 2. Review of Resident #3's signed physician's orders dated 03/06/24 revealed there was an order for blood sugar checks before meals and at bedtime. Observation of Resident #3's Brand A glucometer on 12/10/24 at 11:45 revealed there was a black zippered bag with no name that contained a glucometer labeled with Resident #3's name on the back of the glucometer. Review of Resident #3's Brand A glucometer history revealed the current date in the glucometer was 07/17/24 at 6:34am. Review of Resident #3's November 2024 electronic administration medication record (eMAR) compared to Resident #3's glucometer history from 11/18/24 to 11/30/24 revealed: -There was an entry for blood sugar checks before meals and at bedtime with a scheduled time of 7:30am, 11:30am, 4:30pm, and 7:30pm. -There was documentation Resident #3's blood sugar was checked and recorded before meals and bedtime from 11/18/24 to 11/30/24. -On 11/18/24, at 4:30pm, there was documentation of a blood sugar reading of 236 that was not recorded in Resident #3's	{D 611}		

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glucometer.
-On 11/18/24, at 11:30am, there was documentation of a blood sugar reading of 193 that was not recorded in Resident #3's glucometer
-On 11/18/24, at 7:30am, there was documentation of a blood sugar reading of 103 that was not recorded in Resident #3's glucometer.
-On 11/22/24, at 4:30pm, there was documentation of a blood sugar reading of 194 that was not recorded in Resident #3's glucometer; the blood sugar reading of 194 was on another resident's glucometer.
-On 11/28/24 at 7:30pm, there was documentation of a blood sugar reading of 155 that was not recorded in Resident #3's glucometer.
-On 11/29/24 at 7:30am, there was documentation of a blood sugar reading of 118 that was not recorded in Resident #3's glucometer.
-On 11/29/24 at 11:30am, there was documentation of a blood sugar reading of 119 that was not recorded in Resident #3's glucometer.
-There was 1 blood sugar reading recorded in Resident #3's glucometer from 11/18/24 to 11/30/24 that was not documented on the eMAR; the blood sugar reading was 126.
-On 06/22/24, there was a blood sugar reading of 343 at 2:43am and 189 at 2:44am on Resident #3's glucometer.
-On 06/22/24, there was a blood sugar reading of 289 at 6:07am and 221 at 6:08am on Resident #3's glucometer.

Review of Resident #3's December 2024 eMAR compared to Resident #3's glucometer history from 12/01/24 to 12/09/24 revealed:

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 611}	Continued From page 298 -There was an entry for blood sugar checks before meals and at bedtime with a scheduled time of 7:30am, 11:30am, 4:30pm, and 7:30pm. -There was documentation Resident #3's blood sugar was checked and recorded before meals and bedtime from 12/01/24 to 12/09/24. -On 12/07/24, at 4:30pm, there was documentation of a blood sugar reading of 149 that was not recorded in Resident #3's glucometer. -On 12/08/24, at 7:30am, there was documentation of a blood sugar reading of 89 that was not recorded in Resident #3's glucometer. -On 12/08/24, at 4:30am, there was documentation of a blood sugar reading of 128 that was not recorded in Resident #3's glucometer. -There was one blood sugar readings in Resident #3's glucometer from 12/01/24 to 12/09/24 that was not documented in the eMAR; the blood sugar reading was 69. -On 07/13/24, there was a blood sugar reading of 92 at 3:21am and 69 at 3:29am on Resident #3's glucometer. Interview with Resident #3 on 12/10/24 at 11:35am revealed: -His blood sugar was checked four times a day. -He did not know which glucometer the medication aide (MA) used to check his blood sugar. Refer to the telephone interview with the primary care provider (PCP) on 12/11/24 at 5:30pm. Refer to the interview with a MA on 12/12/24 at 2:41pm. Refer to the interview with a second MA on 12/13/24 at 8:08am.	{D 611}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 611}	Continued From page 299 Refer to the interview Supervisor on 12/12/24 at 3:52pm. Refer to the interview with the Director on 12/16/24 at 5:03pm. Refer to the interview with the Administrator on 12/17/24 at 10:33am. 3. Review of Resident #5's current FL-2 dated 09/21/24 revealed: -Diagnosis included diabetes mellitus type. -There was an order to check blood sugar three times daily before meals and at bedtime. Observation of Resident #5's Brand A glucometer on 12/10/24 at 11:45 revealed there was a black zippered bag with no name that contained a glucometer with Resident #5's name on the back of the glucometer. Review of Resident #5's Brand A glucometer history revealed the current date in the glucometer was 06/16/24 at 11:34am. Review of Resident #5's November 2024 electronic administration medication record (eMAR) compared to Resident #5's glucometer history from 11/18/24 to 11/30/24 revealed: -There was an entry for blood sugar checks before meals and at bedtime with a scheduled time of 7:30am, 11:30am, 4:30pm, and 7:30pm. -There was documentation Resident #5's blood sugar readings were checked and recorded from 11/18/24 to 11/30/24. -On 11/19/24 at 7:30pm, there was documentation of a blood sugar reading of 199 that was not recorded in Resident #5's glucometer.	{D 611}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	R 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 611}	Continued From page 300 -On 11/24/24, at 7:30am, there was documentation of a blood sugar reading of 104 that was not recorded in Resident #5's glucometer. -On 11/28/24 at 7:30pm, there was documentation of a blood sugar reading of 199 that was not recorded in Resident #5's glucometer. -On 11/29/24 at 7:30am, there was documentation of a blood sugar reading of 127 that was not recorded in Resident #5's glucometer. -On 11/29/24 at 11:30am, there was documentation of a blood sugar reading of 104 that was not recorded in Resident #5's glucometer. -There were 3 blood sugar readings recorded in Resident #5's glucometer from 11/18/24 to 11/30/24, that were not documented on the eMAR; the blood sugar readings were 337, 243, and 219. -On 06/05/24, there was a blood sugar reading of 337 at 11:14pm and 243 at 11:15pm on Resident #5's glucometer. -On 06/09/24, there was a blood sugar reading of 219 at 3:30pm and 135 at 3:31pm on Resident #5's glucometer. Review of Resident #5's December 2024 eMAR compared to Resident #5's glucometer history from 12/01/24 to 12/09/24 revealed: -There was an entry for blood sugar checks before meals and at bedtime with a scheduled time of 7:30am, 11:30am, 4:30pm, and 7:30pm. -There was documentation Resident #5's blood sugar was checked and recorded before meals and bedtime on 12/01/24 and from 12/03/25 to 12/09/24; and on 12/02/24 at 7:30am, 4:30pm, and 7:30pm. -On 12/07/24 at 11:30am, there was	{D 611}		

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MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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{D 611}	Continued From page 301	{D 611}		

documentation of a blood sugar reading of 83 that was recorded not in Resident #5's glucometer.
-On 12/07/24 at 4:30pm, there was documentation of a blood sugar reading of 199 that was not recorded in Resident #5's glucometer.
-On 12/07/24 at 7:30pm there was documentation of a blood sugar reading of 192 that was not recorded in Resident #5's glucometer.
-There were 5 blood sugar readings recorded in Resident #5's glucometer from 12/01/24 to 12/09/24 that were not documented on the eMAR; the blood sugar readings were 303, 85, 219, 225, and 83; the blood sugar reading of 194 was documented on two other residents eMARs.
-On 06/20/24, there was a blood sugar reading of 303 at 11:10pm and 142 at 11:12pm on Resident #5's glucometer.
-On 06/22/24, there was a blood sugar reading of 116 at 12:36pm and 85 at 12:38pm on Resident #5's glucometer.
-On 06/23/24, there was a blood sugar reading of 219 at 4:55pm and 85 at 4:56pm on Resident #5's glucometer.

Interview with Resident #5 on 12/10/24 at 11:30am revealed:
-Her blood sugar was checked four times a day.
-Her blood sugar was checked in her room or standing by the medication cart in the hallway.
-She did not know which glucometer was used to check her blood sugar.

Refer to the telephone interview with the primary care provider (PCP) on 12/11/24 at 5:30pm.

Refer to the interview with a medication aide (MA) on 12/12/24 at 2:41pm.

Refer to the interview with a second MA on

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{D 611}	Continued From page 302 12/13/24 at 8:08am. Refer to the interview Supervisor on 12/12/24 at 3:52pm. Refer to the interview with the Director on 12/16/24 at 5:03pm. Refer to the interview with the Administrator on 12/17/24 at 10:33am. 4. Review of Resident 6's current FL-2 dated 05/17/24 revealed: -Diagnosis included diabetes mellitus. -There was an order to check blood sugars three times a day before meals and at bedtime. Observation of Resident #6's Brand A glucometer on 12/10/24 at 11:45 revealed there was a black zippered bag with no name that contained a glucometer with Resident #6's name on the back of the glucometer. Review of Resident #6's Brand A glucometer history revealed the current date in the glucometer was 08/24/24 at 8:41am. Review of Resident #6's November 2024 electronic administration medication record (eMAR) compared to Resident #6's glucometer history from 11/18/24 to 11/30/24 revealed: -There was an entry for blood sugar checks before meals and at bedtime with a scheduled time of 7:30am, 11:30am, 4:30pm, and 7:30pm. -There was documentation Resident #6's blood sugar readings were checked and recorded from 11/21/24 at 4:30pm to 11/30/24 at 7:30pm. -There were exceptions documented from 11/18/24 at 11:30am to 11/21/24 at 11:30am; the exception was the resident was out of the facility.	{D 611}		

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{D 611}	Continued From page 303 -On 11/24/24, at 7:30am, there was documentation of a blood sugar reading of 116 that was not recorded in Resident #6's glucometer. -On 11/25/24, at 7:30am, there was documentation of a blood sugar reading of 112 that was not recorded in Resident #6's glucometer. -On 11/28/24 at 7:30pm, there was documentation of a blood sugar reading of 199 that was not recorded in Resident #6's glucometer. -On 11/29/24 at 7:30am, there was documentation of a blood sugar reading of 129 that was not recorded in Resident #6's glucometer. -On 11/29/24 at 11:30am, there was documentation of a blood sugar reading of 106 that was not recorded in Resident #6's glucometer. -There were 4 blood sugar readings recorded on Resident #6's glucometer from 11/18/24 to 11/20/24, when Resident #6 was out of the facility, that were not on the eMAR; the blood sugar readings were 210, 123, 193, and 103; and 4 blood sugar readings in Resident #6's glucometer from 11/21/24 to 11/30/24 that were not documented on the eMAR; the blood sugar readings were 194, 216, 91, and 301; the blood sugar reading of 194 was documented on two other residents eMARs. -On 07/30/24, there was a blood sugar reading of 277 at 6:14pm and 187 at 6:15pm on Resident #6's glucometer. -On 08/06/24, there was a blood sugar reading of 169 at 5:33pm and 194 at 5:34pm on Resident #6's glucometer. -On 08/07/24, there was a blood sugar reading of 216 at 12:20pm and 174 at 12:21pm on Resident #6's glucometer.	{D 611}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 611}	Continued From page 304 Review of Resident #6's December 2024 eMAR compared to Resident #6's glucometer history from 12/01/24 to 12/09/24 revealed: -There was an entry for blood sugar checks before meals and at bedtime with a scheduled time of 7:30am, 11:30am, 4:30pm, and 7:30pm. -There was documentation Resident #6's blood sugar was checked and recorded before meals and bedtime from 12/01/24 to 12/09/24. -On 12/06/24 at 8:00am, there was documentation of a blood sugar reading of 85 that was not recorded in Resident #6's glucometer; the blood sugar reading of 85 was on another resident's glucometer. -On 12/07/24 at 11:30am, there was documentation of a blood sugar reading of 127 that was not recorded in Resident #6's glucometer. -On 12/07/24 at 4:30pm, there was documentation of a blood sugar reading of 139 that was not recorded recorded in Resident #6's glucometer. -There were 3 blood sugar readings recorded in Resident #6's glucometer from 12/01/24 to 12/09/24 that were not documented on the eMAR; the blood sugar readings were 342, 159, and 55. -On 08/20/24, there was a blood sugar reading of 55 at 6:36pm and 103 at 6:37pm on Resident #6's glucometer. -On 08/22/24, there was a blood sugar reading of 342 at 7:16pm and 133 at 7:17pm on Resident #6's glucometer. Interview with Resident #6 on 12/10/24 at 11:41am revealed: -His blood sugar was checked four times a day by the staff. -He thought he had his own glucometer that the	{D 611}		

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{D 611}	Continued From page 305 facility staff used when his blood sugar was checked. -His blood sugar was checked in his room or in the hallway by the medication cart. -He was in the hospital in November 2024 for a few days. Refer to the telephone interview with the primary care provider (PCP) on 12/11/24 at 5:30pm. Refer to the interview with a medication aide (MA) on 12/12/24 at 2:41pm. Refer to the interview with a second MA on 12/13/24 at 8:08am. Refer to the interview Supervisor on 12/12/24 at 3:52pm. Refer to the interview with the Director on 12/16/24 at 5:03pm. Refer to the interview with the Administrator on 12/17/24 at 10:33am. _____ Telephone interview with the PCP on 12/11/24 at 5:30pm revealed: -Each resident had there own individual glucometer; the glucometer was for single use. -She would check the memory of the glucometer for the residents; if the glucometers were shared the blood glucose readings in the glucometer would not be for the resident she was reviewing. Interview with a medication aide (MA) on 12/12/24 at 2:41pm revealed: -She always used the resident's glucometer when checking blood sugar readings. -She never used a resident's glucometer on a different resident when checking blood sugar	{D 611}		

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{D 611}	Continued From page 306	{D 611}		

readings.
-She did not know why the glucometers had blood sugar readings in them that were not documented on the resident's eMAR.
-The extra blood sugar readings could be a recheck of a blood sugar that was elevated and was not documented.

Interview with a second MA on 12/13/24 at 8:08am revealed:
-Every resident had their own glucometer.
-She did not know how a blood sugar reading was in a specific resident's glucometer and not documented on their eMAR, unless the glucometer was used on different resident.
-Glucometers should not be shared between residents because germs and disease could spread through blood.

Interview with the Supervisor on 12/12/24 at 3:52pm revealed:
-Each resident who had an order for blood sugar checks received a new glucometer with their name on it in September 2024.
-If there were blood sugar readings in glucometers and the blood sugar readings were not documented on the eMAR, then it sounded like someone "messed up".
-The MAs were trained on glucometers about 3 months ago and were instructed not to share glucometers among the residents.
-The training lasted 2 days; it was reinforced weekly to the MAs about single use glucometers and not sharing amongst residents.

Interview with the Director on 12/16/24 at 5:03pm revealed:
-The staff went through training about 3 months ago regarding the proper use of glucometers.
-Glucometers should not be shared between

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{D 611}	Continued From page 307 residents because of the transfers of infection from one person to another. -Each resident who had an order for a blood sugar check had a glucometer with their name on the glucometer and the black zippered bag. -She did not know the resident's name were not on the black zippered bag. -The resident's name should be on the black zippered bag so the MA would know which bag to pick up and not have to open each bag to see whose glucometer was in the bag. -The glucometers used in the facility were single-use glucometers. -She could not locate the infection control policy. -She expected the MA to use the glucometer on the resident that it was ordered for. Interview with the Administrator on 12/17/24 at 10:33am revealed: -Individual glucometers were not to be shared between residents. -There was the possibility of spreading infections between residents if the glucometers were shared. -He expected the MAs to use the correct glucometer on the correct resident. _____ The facility failed to implement infection control measures consistent with the Centers for Disease Control and Prevention (CDC) guidelines resulting in staff sharing glucometers between residents for 4 of 4 diabetic residents, placing the residents at risk for blood borne pathogen diseases. This failure was detrimental to the health, safety, and welfare of the residents, and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/17/24.	{D 611}		